Qualitative study exploring Maternity Ward Attendants' perceptions of occupational (work related) stress and the coping methods they adopted within maternity care settings (hospital) in Nigeria.

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Abstract

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Thesis title: Qualitative study exploring Maternity Ward Attendants' (MWAs) perceptions of occupational (work related) stress and the coping methods they adopted within maternity care settings (hospital) in Nigeria.

Key words: Coping, health outcomes, health and well-being, maternity ward, Maternity Ward Attendants, Nigeria, occupational stress, perceptions, support, workload and work stressors.

Background: Occupational stress is a global and complex phenomenon, and workers in developing countries can be affected by it (International Labour Organisation 2001). Staff within maternity settings have been identified as being at risk of suffering from stress, resulting in adverse health outcomes (Evenden and Sharpe, 2002). However, MWAs' perceptions of stress have not been captured and are not reflected in the literature.

Purpose: The aim of this study was to explore MWAs' perceptions of occupational stress, possible cause(s), the impact and support available and the coping methods they adopted within maternity care settings (hospital) in Nigeria.

Methodology: This study adopted a qualitative methodology. Husserl's (1962) phenomenological approach was chosen as it enabled the researcher to collect rich, in-depth, descriptive accounts of the MWAs' perceptions of the phenomenon under study through the use of semi-structured interviews.

Findings: The major sources of stress for MWAs included work overload, long working hours, staff shortages, work exploitation and intensification and lack of support from senior staff. The stress levels MWAs experienced impacted on their health and well-being and resulted in related behavioural and physical reactions.

Conclusion: This study confirmed that MWAs were exposed to similar stress factors experienced by other health workers and reported in the research literature. Additionally, it demonstrated the need for more qualitative studies to explore the perceptions of occupational stress among under-represented groups of healthcare workers. Importantly, this study created an opportunity to explore the experience of dedicated women facing challenging employment practices in hospital settings in Nigeria. Equally, it gave a voice to these

unrecognised, almost invisible women, who were the MWAs that played a key role within the maternity services.

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List of abbreviations

AHWO: Africa Health Workforce Observatory

AN: Apex Nurse

ASSIA: Applied Social Science Index and Abstracts

CINAHL: Cumulative Index of Nursing and Allied Health Literature

CIPD: Chartered Institute of Personnel and Development.

CNO: Chief Nursing Officer

DFID: Department for International Development

ERI: Effort –Reward Imbalance

FMoH: Federal Ministry of Health

GAS: General Adaptation Syndrome

GDP: Gross Domestic Product

GHQ: General Health Questionnaire

HCA: Healthcare Assistants

HCPs: Healthcare Professionals

HSE: Health and Safety Executive

IMF: International Monetary Fund (IMF)

JDC: Job Demands-Control

LSMoH: Lagos State Ministry of Health

MBI: Maslach Burnout Inventory

MD: Medical Director

MDG: Millennium Development Goals

MSW: Maternity Support Worker

MWA: Maternity Ward Attendant

NANNM: National Association of Nigerian Nurses and Midwives

NDHS: Nigeria Demographic and Health Survey

NGO: Non-governmental Organisation

NHS: National Health Service

NSI: Nurse Stress Index

NSS: Nursing Stress Scale

NVQ: National Vocational Qualification

NMC: Nursing and Midwifery Council

OHSF: Office of the Head of Service of the Federation

OSI: Occupational stress Indicators

OSSAP-MDG: Office of the Senior Special Assistant to the President on Millennium Development Goals

P-E Fit: Person Environment Fit theory

PHC: Primary Health Centres

PPE: Personal Protective Equipment

RCN: Royal College of Nursing

RCM: Royal College of Midwives

SA: South Africa

SDG: Sustainable Development Goals

USA: United States of America

UK: United Kingdom

UNDP: United Nations Development Programme

UNECA: United Nations Economic Commission for Africa

UNFPA: United Nations Populations Fund

UNICEF: United Nations Children's Emergency Fund

WHO: World Health Organisation

WLB: Work Life Balance

WOCQ: Ways of coping questionnaire

CHAPTER 1 INTRODUCTION

1.0 Introduction

This thesis aims to explore within maternity settings in Nigeria, Maternity Ward Attendants' (MWAs') perceptions of occupational stress, possible causes, the impact and support available and the coping methods (if any) they adopted.

Maternity Ward Attendants (MWAs) are a group of unregulated health workers who support midwives to enhance the quality of care a woman and her baby receive (Hussain and Marshall 2011). This thesis provides a phenomenological description of the MWAs' experience of occupational stress and how they cope with this whilst working within the maternity setting.

This chapter outlines the rationale for undertaking this study, considers occupational stress and outlines the aim and objectives. Additionally, a conceptual framework is also presented.

The literature available on stress is dominated by a quantitative approach and MWAs as a group were omitted from many of the key research studies. Consequently, MWAs are an under represented group within research studies, despite working alongside qualified staff in environments where high levels of occupational stress have been identified (McGrath et al. 2003). The limited research on occupational stress and available literature relating to this under represented group formed the rationale for choosing to explore the experience of MWAs for this study.

1.1 Occupational stress

Occupational stress has been defined in several ways with the general notion that it has a harmful effect on an individual, both physically and psychologically (Alves 2005). Occupational stress has become one of the most severe health issues due to its occurrence in a wide range of settings, irrespective of the type of profession; however it is particularly prominent in the care giving sector (Lu et al. 2003; Health and Safety Executive 2012). Researchers have used

different terms to describe occupational stress, including job stress, organisational stress and work-related stress. This is due to the varying descriptions of the concepts of job, occupation, work and organisation (HSE 2002; Vokic and Bogdanic 2007). However, the most consistently used term is occupational stress and this will be used throughout this thesis.

Studies have extensively documented the concept of stress and the connection between stress and ill health, with several interventions used to address the issue (Lazarus and Folkman 1984; Aldwin 2009). However, despite these interventions, occupational stress continues to present as a global health problem with reports indicating high levels of stress experienced by workers, especially amongst the healthcare professions (HSE 2012; HSE 2014). In addition, occupational stress is increasingly linked to other diseases or health problems, including hypertension, cardiac problems, alcohol and substance abuse and an overall decline in the state of an individual's health and well-being (Alves 2005; Sveinsdóttir et al. 2006; Donovan et al. 2013). Due to the effect of occupational stress not only on the health of individuals, but often also on the well-being of their families, the United Nations built upon the Millennium Development Goals (MDGs) by maintaining a continued focus on occupational well-being in the new Sustainable Development Goals (SDGs) which call for a safe and secure work environment for all workers (UN 2015). This extends beyond the physical safety of individuals to protecting their mental well-being through preventative strategies.

Several studies have found that healthcare staff experience high levels of occupational stress which are associated with individual, social, environmental and organisational factors (Edwards et al. 2000; McGrath et al. 2003; Stacciarini and Tróccoli 2004; Ladan et al. 2014). Research has shown that a heavy workload is a major cause of stress (Smith et al. 2000; Calnan et al. 2001; Lee 2003; Li and Lambert 2008; Rickett 2012). Hence, as workload increases, work-related stress increases (Nabirye et al. 2011). This impacts not only on the health and well-being of individuals but is a cost to an organisation in terms of reduced productivity and high rates of absenteeism (Nakakis and Ouzouni 2008). Furthermore, Olofsson et al. (2003) suggested

that high levels of stress may impact on the quality of patient care and possibly threaten their safety due to the increased chances of errors commonly associated with stressed nurses.

Carlisle et al. (1994) and Mander (2009) contended that there is an abundance of research exploring occupational stress within the nursing profession, however, there is a dearth within the maternity services setting. Whilst there is some research examining occupational stress from the maternity service perspective, the actual role of the MWAs within this research is largely absent (Hunter 2001; Thorsen et al. 2011).

The majority of studies have been conducted with staff in more developed countries including the United Kingdom (UK), United States of America (USA), and Australia (Payne 2001; Currid 2008). However, the International Labour Organisation (2001) identified that all societies and occupations are exposed to the effect of occupational stress. Hence, further research needs to be undertaken in developing countries such as Nigeria to explore this issue. One aspect to consider is the potentially significant differences in work settings and practices between countries which may hinder a like-for-like comparison of research findings in relation to occupational stress. At the time of writing this thesis there were no studies on occupational stress and coping that focused on the maternity setting in Nigeria or specifically in relation to Maternity Ward Attendants.

1.2 Aim and objectives of the study

To this end, the researcher explored the following areas around the work experience of MWAs. The main aim of this study was to explore the MWAs' perceptions of occupational stress, possible cause(s), the impact and support available and the coping methods they adopted within maternity care settings (hospital) in Nigeria.

The study objectives are:

1. To explore the lived experiences of occupational stress among MWA's working within hospital maternity settings.

2. To identify the factors that contribute to MWAs' occupational stress.
3. To explore the impact of occupational stress from a MWA's perspective.
4. To analyse the coping mechanisms employed by the MWAs and examine the available support systems for the MWAs (if any).
5. To make recommendations to support the alleviation of stress.

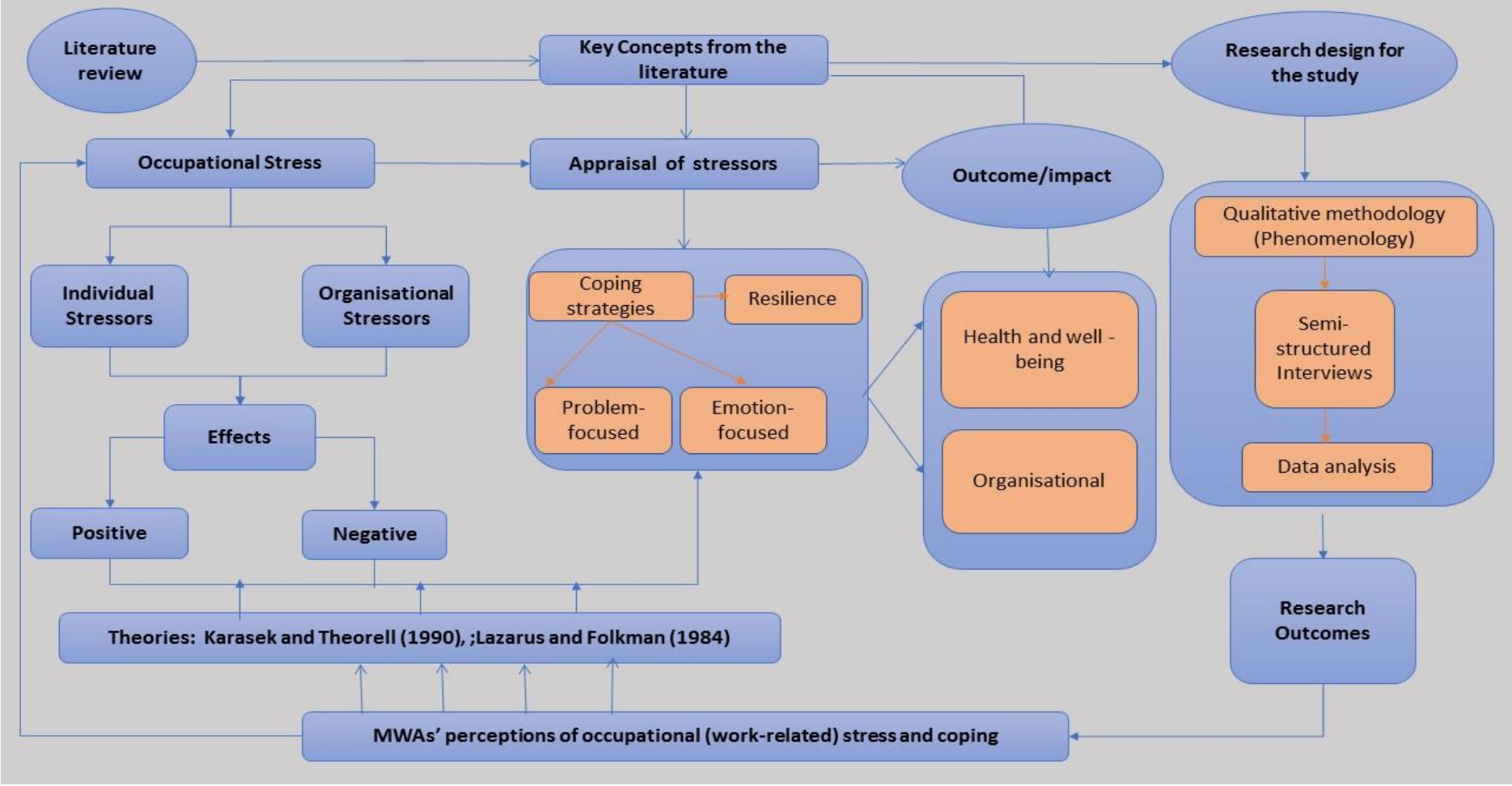
1.2.1 Research questions

1. What are the experiences of occupational stress among MWAs in Nigeria (if any)?
2. What are the major influences/factors that cause occupational stress (if any) for the MWAs?
3. Where it exists, what is the impact of occupational stress for MWAs?
4. What support is available and what are the coping mechanisms used by MWAs?

1.3 Conceptual framework for the study

A conceptual framework is defined as 'a written or graphical presentation that explains the main things to be studied, the key concepts and the presumed relationships among them' (Miles and Huberman 1994: 18). A conceptual framework provides a mechanism for aligning the literature review, supporting theories, research design and the methodology (Ravitch and Riggan 2011). Miles and Huberman (1994) suggested that the conceptual framework is best represented graphically rather than in text. Figure 1 provides a pictorial representation of the key concepts used within the study and the research design adopted. The main components within the conceptual framework are sources of stress (stressors), appraisal of stressors and the outcomes for/impacts on an individual's health and well-being. (Figure 1).

Figure 1: Conceptual framework of the study



Source: Developed by the researcher adapting Vaughan (2008).

1.4 Significance of the study

The literature review (Chapter 3) identified an abundance of research into the potential sources of occupational stress and its effects on health and well-being among a diverse population of healthcare workers in developed countries including the UK (Healy and McKay 2000; Payne 2001; Li and Lambert 2008). Although a few studies included midwives, none has focused on MWAs. Consequently, very little research on the above concept has been conducted in Africa, specifically Nigeria, and none in the maternity setting.

The concept of occupational stress is a global and complex phenomenon and workers in developing countries are undoubtedly affected (International Labour Organisation 2001). It has been asserted within the literature that occupational stress can also be attributed to cultural conditions, pressures and local forces which need to be understood (Nabirye et al. 2011).Therefore, there is a need for more research within the field of occupational stress in developing countries. Hence, using a phenomenological methodology provides an opportunity to adopt a more explorative approach to understanding the concept of occupational stress, specifically among MWAs.

The lack of focus on MWAs in developing countries identified them as an under-represented or under-recognised group within the body of research. This is a situation not dissimilar to that of maternity support workers (MSWs) in the UK (Thornley 2008; Griffin et al. 2009). The MWAs are a growing population of health workers within the maternity workforce in both developed and developing countries (Griffin et al. 2009). This thesis represents a critical first step in beginning to address the gap in the literature as the study of occupational stress is still fairly new in developing countries, including Nigeria. Furthermore, it is important to understand the nature and causes of occupational stress and the level of support available to cope and mitigate against the resulting effects.

In addition, this research hopes to have a wider impact, not only enhancing the health and well-being of respondents but also improving health outcomes

for mothers accessing maternity care in Nigeria. According to the Royal College of Midwives (2014), promoting the health and well-being of midwives directly contributes to high quality maternity care for women and babies. This implies that where staff well-being is good, the quality of patient care and their experience of maternity services tend to be positive (Team et al. 2010; Maben et al. 2012).

1.5 Thesis structure

Chapter one provided an introduction to the study with an outline of the aim, objectives and research questions. A brief introduction to occupational stress, the conceptual framework (Figure 1) and significance of the study and the thesis structure was also detailed.

Chapter two provides a contextual description of Nigeria where the study was conducted and an overview of the current status of maternity care, including maternal mortality rates in Nigeria. In addition, an outline of the United Nation's 2030 sustainable development goals (SDGs) and the preceding millennium development goals (MDGs) and the relevance of these to this study is discussed (United Nations Development Programme 2015). It is noteworthy that the MDGs were still in force when this study began. However, during the course of the research the 2030 SDGs were introduced (United Nations Development Programme 2015). These will be discussed further in the chapter.

Chapter three provides a literature review and examines the meaning of stress, particularly occupational stress and other related concepts. The different theoretical frameworks used to explain the concept of stress and the adopted model for this study are also detailed within this chapter. In addition, relevant literature related to the MWAs' role will be discussed in the literature review section. This chapter therefore provides a general overview of the concept of occupational stress and coping mechanisms, and more specifically the implications for the MWA role within a Nigeria setting.

Due to the explorative nature of the study Husserl's (1962) phenomenological approach was used to examine the socially constructed perceptions of MWAs in relation to occupational stress and coping (Moustakas 1994). Chapter four examines the philosophical underpinning, methodology and data analysis, including possible ethical issues associated with undertaking this study. An explanation of the approach to sampling, a description of the study sample, an account of the field work and data collection is included.

Chapter five presents the detailed findings from the interviews conducted with the MWAs. This chapter includes analysis and quotes from the 22 MWAs interviewed which presents their perceptions of occupational stress experienced within the maternity setting. In addition, MWAs' descriptions of the impact stress has on their health and well-being and the coping methods they adopted are discussed. The findings of the study are reviewed in the context of literature in Chapter six. Chapter seven provides the concluding remarks to this study, returning to the aim and objectives and how they were achieved with reference to the study findings. In addition, the recommendations for minimising or alleviating stress amongst MWAs and the implications for future research are detailed in this chapter. The research contribution, strength and limitations of the study and, the researcher's reflections are also included within this chapter.

1.6 Summary

In summary this study aims to contribute to the body of knowledge on the concept of occupational stress, specifically in developing countries, and also increase the representation of MWAs within key research. In addition, it is hoped that results from this study will lay the foundation for further research in the field of occupational stress and coping in maternity services, especially among MWAs and their peers in developed countries. Due to the key role MWAs play in the maternity setting, they could be exposed to an array of potential sources of stress. Thus, identifying these will not only improve MWAs' health and well-being through interventions specific to their work environment, but may also ensure increased satisfaction for Mothers accessing maternity services.

CHAPTER 2 BACKGROUND TO THE STUDY

2.0 Introduction

This chapter provides a brief contextual description of the country of study, Nigeria. This includes the demography of Nigeria, the structure and characteristics of the healthcare system and its workforce. A brief justification for conducting this study in Nigeria will also be included. Additionally, the concept of brain drain, the impact this has on the healthcare system and the nursing/midwifery educational system will be described briefly. The United Nations (UN) MDGs and 2030 SDGs and their relevance to this study will also be discussed. This chapter will conclude with a description of the MWAs' role within the maternity setting using the literature on healthcare assistants and maternity support workers in developed countries such as the UK to aid the discussion.

2.1 Country of study: Nigeria's demography

Nigeria is a country located in West Africa (Figure 2) (World Bank 2014a). It is officially called the Federal Republic of Nigeria and the capital is Abuja. Nigeria borders the Republic of Benin, Chad, Cameroon, Niger and its South coast lies along the Gulf of Guinea. The country has 36 states grouped into six geo-political zones, namely North-West, North-East, North-Central, South-East, South-West and South- South (Figure 3) (National Population Commission (NPC) 2014). Nigeria covers a total of 356,667 square miles of land, stretching from the Gulf of Guinea on the Atlantic coast in the South to the fringes of the Sahara desert in the North (World Bank 2014a). Nigeria is the most populous country in Africa and the 14th largest in land mass (World Bank 2014a). It has a rich ethnic diversity with over 250 ethnic groups, including Hausa, Igbo and Yoruba, which are the major groups (NPC 2014). Another factor within the Nigerian society is a sense of strong religious belief and the majority practise either Christianity or Islam.

Nigeria has the second largest economy in Africa with a Gross Domestic Product (GDP) of $521.8 billion, a GDP growth of 5.4% and inflation of 8.5%

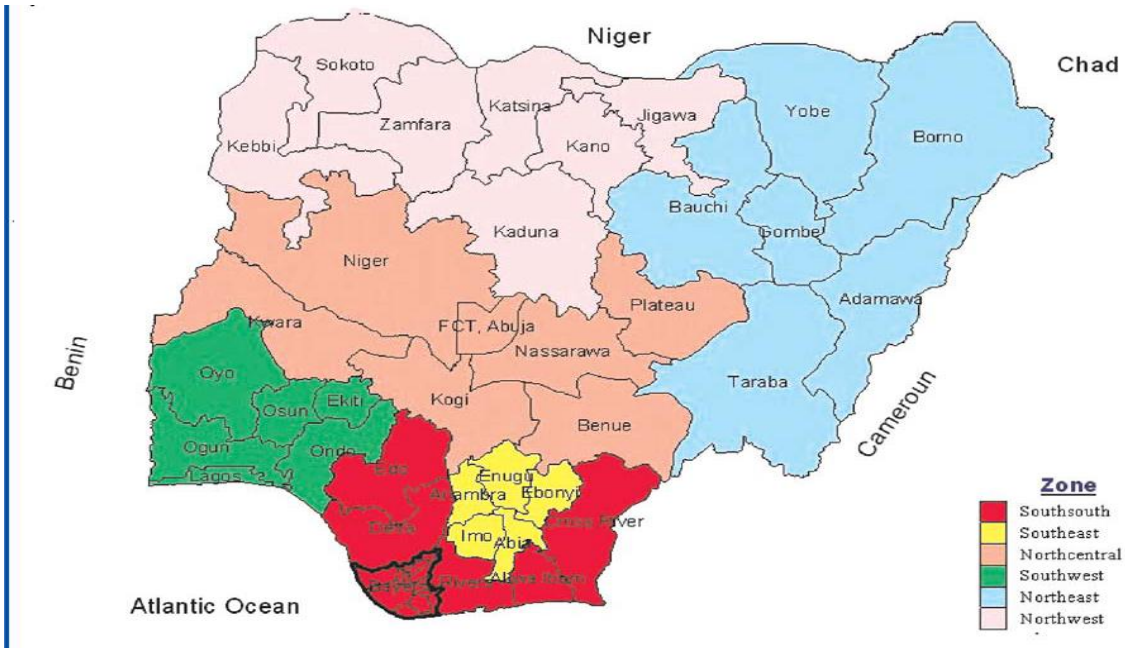
in 2013 (World Bank 2014b). The most recent reports shows Nigeria has Africa's biggest economy taking over from South Africa (SA) (Deloiite 2014; Deloiite 2016). The last Nigerian census in 2006 showed the country's population stands at 140,431,790 people with 71,345,488 males, 69,086,302 females and an under-five population of 29,697,225 (NPC 2014). However, recent statistics show an increase in this figure to a total population of 173.6 million in 2013 (World Bank 2014b). According to the WHO (2014), the birth rate in Nigeria is 41.5 compared to 12.3 in the United Kingdom (UK). This implies 41.5 live births per 1000 population occurring within the year.

The Nigeria Demographic and Health Survey which was undertaken in 2013 noted that the total fertility rate (TFR) was 5.5 births per woman, furthermore, Nigerian women, on average will give birth to 5.5 children by the end of their childbearing years (NPC 2014). Despite the global longevity, life expectancy at birth in Nigeria is 53 years for males and 55 years for females (WHO 2014). This is considerably lower when compared to developed countries, including the UK where life expectancy in England and Wales combined is 79.3 years for males and 83.0 years for females (Office for National Statistics (ONS) 2014).The largest and most densely populated state in Nigeria is Lagos state, located in the South-Western region (Appendix 1).

Figure 2: World map showing Nigeria.

Source: UN Cartographic section (2014).

Figure 3: A map of Nigeria showing the six geo-political zones.



Source: WHO (2007)

2.2 The healthcare system in Nigeria

The Nigerian healthcare sector is comprised of a wide range of providers from both the public and private sectors. These include public facilities managed by the government, private-for-profit providers, non-governmental organisations (NGOs), traditional care providers and community and faith based organisations (WHO 2002) .

Nigeria is a federation that has three tiers of government: Federal, State and local (WHO 2002). These share the responsibilities for providing health services and programmes (Appendix 2). The Federal government, through the Ministry of Health, is largely responsible for providing guidance, planning, technical assistance and coordinating the state level implementation of the National Health policy (Federal Ministry of Health (FMoH) 2009). Within the Federal Ministry of Health, there are different departments, including the family department, which is concerned with creating awareness on reproductive, maternal, neonatal and child health issues (FMoH 2009). The Department of

Hospital Services supervises over 53 federal tertiary hospitals including teaching hospitals, federal medical centres and national eye clinics. The State Ministries of Health are responsible for secondary hospitals, regulating and providing technical support for the primary healthcare services at the local levels (FMoH 2009).

The Lagos State Ministry of Health (LSMoH) is responsible for the health of people within the state. Healthcare in the state is organised into three levels: primary, secondary and tertiary. There are eight maternal and child health centres (complexes) each with 100 to 110 beds, 277 Primary Health Centres (PHCs), 2 teaching hospitals and 26 secondary facilities (general hospitals) in the state (United Nations Populations Fund 2010; Adeshina 2013). The PHCs are the point of entry for antenatal care and will identify problems in pregnancy early on (Abimbola et al. 2012).

Between 2010 and 2012, approximately 45,249 babies were delivered in five maternity hospitals in Lagos (Lagos State Government (LSG) 2012). The inconsistency in data makes it difficult to provide accurate statistics on the births per hospitals or the workforce employed in the state. However, an earlier study reported that 7200 deliveries occurred between 1st of January, 2005 and 31st of December, 2006 in one of the largest and busiest maternity hospitals in the state, which is also called a 'baby factory' by the public (Fabamwo et al. 2006).

Although, the above structure may seem to depict a well-coordinated healthcare system, in reality it is not seamless and there is duplication and confusion over roles and responsibilities among the different tiers of government (UNFPA 2010). This has led to a problem with coordination, tracking performance and bench marking healthcare systems. There are also wide regional disparities in status, service delivery and resources available, that characterise the Nigerian healthcare system (UNFPA 2010).

2.2.1 The Nigerian Health Workforce

Healthcare human resources are described as individuals who are employed to promote and preserve health including the diagnosis and treatment of diseases (WHO 2006). This includes support workers, who help make healthcare systems function (Federal Ministry of Health (FMoH) 2007). The health workforce is, therefore, a key factor in determining health outcomes, driving healthcare systems performance and meeting goals, including MDGs (WHO 2006).

Nigeria has one of the largest healthcare workforces in Africa and is comparable to Egypt and South Africa (FMoH 2007; AHWO 2008). However, one of the major challenges faced in Nigeria is the availability and retention of an adequate pool of competent staff to provide the required healthcare services (FMoH 2007). Consequently, Nigeria faces a crisis due to workforce shortages. The extent of the labour shortages in Nigeria is difficult to determine as the workforce data is unreliable due to incomplete and fragmented data management systems. Another key contributing factor that challenges the organisation of health care is the extensive 'brain drain' of health staff (see 2.2.2).

The healthcare workforce is unevenly distributed across the six geopolitical zones in Nigeria and between urban and rural areas (UNFPA 2010). This is, partly, due to insufficiently resourced and neglected healthcare systems and the poor human resources planning and management practices used by different organisations (Oyetunde and Ayeni 2014). This has created an acute workforce shortage leading to poor health outcomes and increased maternal mortality rates in different regions. Although different cultural and environmental factors can contribute to mortality rates, the lack of appropriate personnel still remains a major cause of poor quality of care (Oyetunde and Ayeni 2014). Other challenges include a poor infrastructure, irregular payment of salaries, job insecurity, limited health budget, workload issues and lack of opportunities for career development which are associated with occupational

stress and influences health outcome (UNFPA 2010; KPMG 2012; (Horrocks and Johnson 2014).

The persistent difficult economic conditions in Nigeria have resulted in problematic healthcare situations and employment hardship. While a population of over 140 million, high birth rates and rising maternal mortality combine to increase the burden of health care provision (Babalola and Fatusi 2009). The Nigerian government has limited resources, including an inadequate workforce to cater for the health needs of its growing populace (AHWO 2008). This situation is worsened by financial misappropriation, lack of accountability, political motives and the inappropriate geographical distribution of available resources and staff (AHWO 2008; Majekodunmi and Awosika 2013). This has created a burden for the current staff who have to work with limited resources, experience coercion to work below standards and yet need to achieve the goals of providing health care to the populace. Consequently, there are concerns for the quality of health care provided in the midst of known limitations. Despite this, it should also be noted that these challenges to healthcare services are not restricted to Nigeria alone but extend to other parts of West Africa (Nabirye et al. 2011).

2.2.*2* Brain drain and the Maternity Ward Attendants

The concept of 'brain drain' is not a new phenomenon and is a global issue that has challenged Africa, and specifically the health care sector, due to the loss of workforce (Dodani and LaPorte 2005; Serour 2009). The 'brain drain' occurs mainly with the migration of workers from low to high resource countries and from rural to urban areas (Serour 2009). As a consequence, skilled professionals/health workers, including doctors and midwives, migrate from Nigeria to work in high income countries such as the UK and the USA (Stilwell et al. 2004). The reasons cited for healthcare workers migrating is the inadequate infrastructure and poor compensation packages (salaries) in their home country and the search for better working environments elsewhere (Serour 2009).

According to Stilwell et al. (2004) Nigeria is one of the major health worker exporting countries in Africa. However, due to the scarce and unreliable workforce data in Nigeria, accurate figures are difficult to obtain. The problem of a 'brain drain' is further compounded by recruitment agencies operating in countries who recruit healthcare workers from poorly resourced countries, such as Nigeria, to fill vacancies in the UK and USA (Stilwell et al. 2004; Uneke et al. 2008).

The negative impact of a 'brain drain' within the healthcare sector is wide spread, resulting in depleted staff, reduced patient safety and poor quality of care delivery (Dodani and LaPorte 2005). The maternity setting is one of the areas most affected by the 'brain drain' phenomenon (Serour 2009). Consequently in Nigeria, high birth rates and the continuous migration of skilled healthcare workers have contributed to the high rate of maternal and new-born mortality (Uneke et al. 2008). Thus, delivering maternity care depends largely on the availability of adequate numbers of skilled healthcare workers, including midwives (Stilwell et al. 2004; Serour 2009). However, the shortages of skilled health workers has led to a greater reliance on the MWAs in an effort to meet the demands within maternity settings (Adamu et al. 2003).

2.2.3 Nursing and midwifery education/training and career pathway in Nigeria

In Nigeria, there are several health training institutions distributed across the country (Africa Health Workforce Observatory (AHWO) 2008). There are 71 nursing and midwifery schools in Nigeria which have similar entry requirements for students as the medical schools (AHWO 2008). Students are required to pass practical, written and oral examinations before they can be awarded their degrees. Nursing and midwifery courses are four to five academic years long depending on the mode of entry and nurses are awarded the degree of Bachelor of Science with Honours (AHWO 2008). However, not all these institutions award degrees because they also offer a 12 to 18 month post-secondary study for a Diploma of Midwifery or three years for Registered Nurse certificate. Graduates from these programmes are awarded their certificates by the Nursing and Midwifery Council of Nigeria (NMC) (AHWO 2008). The NMC is the statutory body that governs the conduct of the Nursing

and Midwifery profession in Nigeria. Similarly, in the UK the Nursing Midwifery Council (NMC) is the regulatory body that regulates Nurses, Midwives and Health visitors in England, Wales, Scotland and Northern Ireland (NMC 2015). The NMC sets standards and codes of conduct for nurses and midwives. The NMC in the UK, just like in Nigeria, maintains a professional register for these professions (NMC 2015).

Besides the NMC, which is government controlled, the National Association of Nigerian Nurses and Midwives (NANNM) is a trade union for nurses and midwives that is totally independent of the government (NANNM 2014). The main objective of this association is to organise and provide a forum where nurses and midwives can speak with one voice (NANNM 2014). This association offers support to its members across a diverse range of activities and seeks to enhance the dignity of the profession (NANNM 2014). This differs to the UK, which has different professional trade unions for nurses and midwives, namely the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM). Similar to the NANNM, the RCN is the largest union of nurses in the world, with more than 300,000 members, and excludes the RCM membership which is specifically for midwives and members of the maternity team (RCN 2015; RCM 2015).

In Nigeria, a newly qualified and registered nurse/midwife starts as a nursing officer II and progresses by promotion after spending three years on each role through to the position of Chief Nursing Officer (CNO) depending on the availability of a vacancy (Office of the Head of service of the Federation (OHSF) 2008).This is the senior grade in the nursing career framework. There is the potential for nurses to progress to the level of assistant director and director of nursing at the Federal tier of government. Furthermore, the most senior appointment for a nurse/midwife is the permanent secretary of a ministry with the potential of advancing their career to the post of a Minister of Health (OHSF 2008). This post is by political appointment and recommendations are made by senior government officials through the presidency and confirmed by the House of Senate (OHSF 2008). The promotions and progressions do follow due process according to the public

service rules based on qualifications and further education. However, they can be politically disrupted by other interested parties lobbying for positions or imposing their own candidates (Majekodunmi and Awosika 2013). The Nigerian nurses' career path is to an extent similar to UK nurses. However there are different routes for accessing the nursing and midwifery profession in the UK, either by being a NHS care assistant or NHS apprentice (NHS Careers 2015). Based on the level of experience and recommendations from an employer, care assistants or apprentices can be supported to undertake pre-registration qualifications (NHS Careers 2015). This provides the opportunity for successful candidates to progress in their career as nurses in different specialisms and to become senior members of the nursing team. However, in Nigeria there is no similar educational/career opportunities or pathways for MWAs.

2.3 Maternal and child healthcare status in Nigeria

Maternal health is described as the health of a woman during pregnancy, child birth and postpartum (WHO 2014). Motherhood is often a positive and cherished moment for most women. Pregnancy and childbirth complications are one of the leading causes of death and disability among women of reproductive age (Ajaegbu 2013). Nigeria ranks 10th among countries with the highest child and maternal mortality. It is estimated that 14% of global maternal mortality occurs in Nigeria (Brals et al. 2013; United Nations Economic Commission for Africa 2013). In 2008, an estimated 358,000 women died due to complications developed during pregnancy and child birth, and of this figure Africa and Asia account for 87% (WHO 2010). One in every 31 women dies during pregnancy or child birth, with at least 20 more suffering from injuries or maternal disability in sub-Saharan Africa compared to one in 4,200 in Europe (WHO 2010). According to the Nigeria Demographic Health Survey conducted in 2013 report, under-five mortality is 128 deaths per 1000 live births, a decline from 201 deaths in 2003.

Maternal and child mortality is not an uncommon occurrence in several parts of the developing world (Ogunjimi et al. 2012; WHO 2014). However, Nigeria

accounts for 10% of the world's maternal and under-five mortality rate (Department for International Development (DFID) 2011). This is not only due to the large population but also because of the high maternity ratio (Babalola and Fatusi 2009). Other leading causes of maternal mortality in Nigeria include haemorrhage, sepsis, preeclampsia/eclampsia and a lack of adequately and appropriately trained health staff which increases the chances of a woman dying from these conditions (Gooke and Tahir 2013; Say et al. 2014). The maternal mortality ratio between 2008 and 2013 is estimated to be between 545-630 per 100,000 live births (Onasoga et al. 2014; WHO 2014).

According to the NDHS undertaken in 2013, 36% of births in Nigeria are delivered in a health facility. Some 23% occur in the public sector, 13% in private facilities and 63% are delivered at home, specifically in the rural North-Western Zone. However, only 41.5% of births are registered, despite Nigeria having a statutory law on birth registration (United Nations Children's Emergency Fund 2014). The Nigerian Federal Government's Birth, Death Etc. (Compulsory Registration) Act (decree No. 69 of 1992) requires all parents or persons who know about the birth to register a child within 60 days of birth or face a penalty (*Birth, Death, Etc (Compulsory registration) Act,* Birth, Death, Etc. (compulsory registration) Act 1992,). However, this penalty has proved unsuccessful as it is waived in most cases and has not been fully implemented. The lack of awareness of the law has also been another contributing factor to the low birth registration rate in Nigeria (UNICEF 2007) .

2.3.1 Maternal health, Millennium Development Goals and this study

The unhealthy trends in the years preceding the new millennium, including a record high of 546,000 maternal deaths globally in 1990, became an issue of international concern and required a concerted approach from countries to improve public health and well-being in year 2000 (United Nations 2000). This led to a UN Millennium declaration setting a series of time bound targets with a deadline of 2015 that committed member nations to a new global partnership to reduce poverty and improve public well-being (UN, 2000) . The following year the MDGs (Appendix 3) were published (Zureick-Brown et al. 2013).

The persistent high rates of maternal and child mortality in Nigeria reduced the chances of achieving millennium developments goals (MDGs) 4 and 5 (MDG 4: Child health and immunisation and 5: Maternal and reproductive health). According to the United Nations Development Programme (2010), Nigeria continues to record unacceptably high maternal, new-born and child mortality rates and is not listed among the 10 countries to have made rapid progress to meet the MDG goals. This is not to say efforts were not made by the Nigerian government; however, only a marginal reduction was noted in the last five years and this was not sufficient to achieve MDG 5 (UNDP 2010; OSSAP-MDG 2015).

Therefore, as a result of the global and national emphasis on meeting the MDGs and reducing Nigeria's high level of maternal mortality, research in maternal care has become of great significance, specifically that relating to the workforce. Hence, it has been recognised that to ensure the MDGs are substantially achieved, it is not enough to have the right facilities, but there is also a requirement to have a healthy workforce (UNDP 2010). This is due to the crucial role the workforce plays in ensuring the effective provision of services and particularly maternal care. In addition, although not specifically mentioned in MDG 6 (Combat HIV/AIDS, malaria and other diseases), occupational stress has for some time been linked both directly or indirectly to other diseases, including cardiovascular diseases (Krantz and McCeney 2002). Occupational stress could therefore threaten the well-being of individuals. An understanding of the impact of occupational stress on health and well-being can be beneficial in eradicating other associated diseases and increase the chances of meeting the targets within MDG 6.

In 2015, the MDGs were replaced by a transformative 2030 agenda for sustainable development (UNDP 2015). This agenda has 17 sustainable development goals (SDGs) to be achieved over the next 15 years (Appendix 4). Despite the significant progress made with the MDGs, health and well-being continues to be a challenge in most countries. Therefore, following on from MDG 6, SDG 3 is focused on 'ensuring healthy lives and promoting well-being at all ages'. Specifically pertaining to this study is goal 3 C, which has a specific focus on '...the recruitment, development, training and retention of the

health workforce in developing countries' (UN 2015 : 17). Thus, the findings and recommendations from this study could contribute to achieving SDG 3 C.

2.4 Maternity Ward Attendants

Historically, Healthcare Assistants (HCAs) have been employed in different areas within the Nigerian healthcare system. A wide variety of titles has been used to describe their role, for example Ward Attendant and Nursing Assistant (United Nations Populations Fund 2010) and often titles are used interchangeably. The MWAs are classified as unskilled healthcare workers and are ranked among the junior cadre within the Nigerian healthcare system. Over half (52.8%) of the Nursing Assistants or Ward Attendants are employed in general hospitals, which also have the highest numbers of maternity beds (UNFPA 2010). The WHO has referred to such support workers as the ''invisible backbone'' of the health system (WHO 2006: 4).

Internationally, the HCA role has developed over the years. Originally they were described as Auxiliary Nurses but different titles, including Ward Assistants and Healthcare Support Workers, were used to describe the role (Thornley 2000). In the UK, HCAs are referred to as Maternity Support Workers (MSWs) and are employed within the maternity services to support the work of the qualified midwives (Griffin et al. 2010). There is a disparate range of titles used to describe these roles, including Maternity Assistants, Maternity Support Workers and Maternity Care Worker/Assistant (Griffin et al. 2010). However, the role is now widely referred to as the MSW (Griffin et al. 2009). It is also noteworthy that the most consistently used title in Nigeria is the Maternity Ward Attendant. Hence, for ease of reference within this thesis, this group of health workers in the UK and their colleagues in Nigeria will be referred to as MSW and Maternity Ward Attendants (MWAs) respectively.

In Nigeria, the MWAs have similar duties to their counterparts in the UK. In some parts of Nigeria the MWAs are called 'birth attendants' or 'unskilled birth attendants' (Ezeanochie et al. 2010; United Nations Populations Fund 2010). However, just like their counterparts in the UK, little recognition is given to

them and the important role they play within the hospitals. The omission of MSWs from the UK Cavendish (2013) provides further justification for the need for more research focusing on this role, given the crucial part they play in maternity services globally.

Although, the focus of this study is on the MWA in Nigeria, the literature on MSWs in the UK was used to inform the review of this group of under-represented health workers. It is worthwhile noting that the researcher acknowledges the maternity setting in the UK is different to that in Nigeria. The lack of research articles and reports concerning MWAs in Nigeria may be attributed to the limited opportunities for those interested in exploring this topic due to a lack of resources, skills and time (Adejumo and Lekalakala-Mokgele 2009).

The number of MSWs recruited to the maternity services in the UK has increased over the years from 77.4% in 2007 to 90.6% in 2009 (RCM 2010a). There are a number of contributing factors to this rise, including the national shortage of midwives, recruitment and retention problems, an increase in birth rates and midwifery role expansion (Lindsay 2004; Griffin et al. 2012). These factors produced a strain within the UK maternity services, leading to a further demand on the midwives' time (Lindsay 2004). This increased the need for more MSWs to be recruited to address this workload problem and to free up more time for a professional-initiated direct patient care for service users (Hussain and Marshall 2011). Although the MSWs have been identified as key to reducing midwives' work pressures, midwives are sceptical about delegating roles, and particularly 'the caring bits' or 'being with women', for fear of losing the main reason why they became a midwife (Prowse and Prowse 2008). Despite this scepticism the delegation of work has increased the pressure on MSWs.

In Nigeria, the critical shortage of professional health workers including midwives, an ageing population of midwives, high population growth and birth rates have led to an increase in the number of MWAs recruited (Adegoke and van den Broek 2009; United Nations Populations Fund 2010). These

challenges are not dissimilar to those faced in the UK (RCM 2013). The MWAs in Nigeria are recruited using different criteria and there is not a consistent approach to recruitment (AHWO 2008).

In the UK, MSWs are not regulated by any professional body; however they can join the Royal College of Midwives as a MSW member (RCM 2010a; RCM 2016a). MSWs' roles have traditionally included undertaking a range of general household or clerical/administrative duties to support care, including making beds and distributing meals (Griffin et al. 2010). These tasks are referred to as 'non-professional duties' (McKenna et al. 2002). More recently, roles have evolved to allow MSWs to work more directly with assisting midwives and include helping women with personal hygiene, demonstrating infant bathing techniques, assisting in antenatal classes, acting as runners during theatre procedures or assisting with infant feeding (Tope et al. 2006). It was also noted that there is a disparity in tasks undertaken by the MSW depending on the individual delegation by midwives and hospitals or wards where they work. Some MSW go as far as standing at the ward door during visiting to ensure no more than two visitors are admitted to visit each woman, while others carry out more clinical duties with the exception of delivering babies (Tope et al. 2006; Hussain and Marshall 2011).

The responsibilities of the MWA in Nigeria vary based on the hospital and the roles/tasks midwives delegate resulting in a lack of role clarity (UNFPA 2010). However, the main MWAs' responsibilities include: laboratory runs (taking blood samples for test), administrative duties during ante-natal sessions, preparing the labour ward, cleaning the ward and/or attending to the mother after delivery in some cases (UNFPA 2010; Ezeanochie et al. 2010). More widely, MSW/MWA carry out a number of postnatal tasks, including weighing babies, providing support for women with feeding, bathing and other aspects of new born care (Jameson 2012). Other tasks undertaken on postnatal wards may include post-operative observations; however the midwives remain professionally responsible for any work carried out on their behalf (Jameson 2012). In the UK a RCM position statement (2010:1) on MSWs' roles and responsibilities stipulates they are to undertake work that does not require

midwifery training or registration but it needs to be under the supervision of a midwife. There is no equivalent statement for MWAs in Nigeria.

Sandall et al. (2007) argued that MSWs contribute to improving quality in maternity care by delivering an efficient and effective service to women. In contrast, MWAs in Nigeria have been key to closing the gap in the maternity care workforce with a great reliance on them in some parts of the country, including the Northern region (Adamu et al. 2003; Lewis Wall et al. 2004). However, unlike the MSWs and Midwives in the UK who benefit from RCM guidelines that provide boundaries between roles, these are absent in Nigeria.

The training of MSW in the UK has been fragmented over the years with varying approaches adopted in different NHS Trusts. While some MSW have undertaken training specific to their roles, others have obtained National Vocational Qualification (NVQ) at level one, two or three (Lindsay 2004; Griffin 2007).

However, while the level of training and certification required for the role of the MSW in the UK is still under development, MWAs in Nigeria do not have any formal training in place. Generally, MWAs undergo training through on-the-job experiences with very few taking short-term programmes offered by some colleges or organisations like the Red Cross (UNFPA 2010).

2.5 Summary

In summary, this chapter presented information about Nigeria, the region of study, the characteristics of the population and the Nigerian healthcare system. An overview of the education system pertaining to the nursing and midwifery profession, and the challenges to career advancement were also presented. Additionally, this chapter identified the factors that challenge the healthcare system and the quality of care provided, including staff shortages as a consequence of brain drain. The United Nations MDGs and SDGs and its relevance to this study was presented in this chapter. Furthermore, the justification for Nigeria as the study location was also detailed in this chapter. The role of the MWA was outlined, together with some of the limitations.

Chapter three will present the literature review, which provides the meaning of stress and relevant theories, and the evidence base for this study.

CHAPTER 3 LITERATURE REVIEW

3.0 Introduction

This chapter initially provides a description of the search strategy used to identify the publications for the literature review. An overview of the meaning of stress and occupational stress is given, and key theories used by various researchers to explain these concepts are detailed in this chapter. The literature review examined occupational stress among health workers and in relation to maternity services. However, the literature on occupational stress in maternity settings was limited and very little from a Nigerian perspective was available. Therefore studies of other health staff were used to explore these areas. The possible causes and effects of occupational stress and the support and coping methods used by other health professionals are detailed within this chapter. This chapter concludes with a summary of the articles reviewed, which partly informed the methodology adopted within this study.

3.1 Literature search strategy

An electronic search of relevant literature and databases was undertaken that included the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, Applied Social Science Index and Abstracts (ASSIA) and Medline (Table 1). The literature review included articles published from 2000 to 2015 in peer-reviewed journals. This range was chosen to ensure articles included were contemporary and a robust review of the literature over a period of time. The PICO (patient or problem, intervention, comparison, outcomes) principle was used to guide the literature search strategy which involved using a combination of key words (Akobeng 2005). These keywords included: ‘healthcare assistants, auxiliary nurse, maternity support workers, birth attendants, maternity ward attendants, nursing assistant, health personnel, care assistant’, ‘stress, occupational stress, job related stress, work related stress, work pressure, work tension, work intensification, work strain, distress, role stress, psychological stress, burnout, caring’, ‘training, organisational support, coping, hardiness, resilience’, and ‘maternity service, midwives, midwifery, Nigeria, Nigerian health system, maternity hospital’.

Additionally, due to the limited results yielded by the initial searches, the key words ‘nurse’ and ‘nursing’ were subsequently included.

In addition, websites such as the Health and Safety Executive, the Royal College of Midwives, World Health Organisation, the Department of Health, the Nigerian Federal Ministry of Health and the Lagos State Ministry of Health, were used to source additional information. Relevant books and print materials were also sourced from the university’s library for additional resources including Human resource (HR) literature applicable to the study.

All the identified literature was reviewed irrespective of the research methodologies used. The search was narrowed by using inclusion and exclusion criteria, for example limiting the date of publication to the period from 2000 to 2015 in order to review more recent literature and associated findings. A funnel approach was applied whereby the titles of the search results were read and a folder of possible articles for review was created (Bowling 2009). The abstracts of the retrieved articles were scrutinised against the inclusion criteria to ensure that the most relevant studies were selected and unrelated articles excluded. The references contained within these articles were then hand searched to identify additional publications. Although a time limit was set for the above, older articles that were exceptionally relevant, together with articles containing seminal work were also reviewed and included as appropriate. This approach enabled the research to set clear boundaries, include contemporary research and seminal work to enhance the understanding of the development of stress and coping. Some of the research findings included in the literature review had small sample sizes and limited response rates. These limitations will be discussed in the literature review.

Inclusion criteria

1. Primary research studies, literature reviews, policies and official reports.

2. Published in English between the years 2000 to 2015. Seminal literature on the development of stress and coping strategies that may be outside of this date range.
3. Focus on occupational stress and coping in the healthcare professions.
4. Focus on staff including healthcare assistants (HCAs) and maternity support workers (MSWs)/MWAs in hospital settings.
5. Relevant human resource management studies.
6. Relevant books pertaining to occupational stress, coping and human resources.
7. Studies with qualitative, quantitative and mixed method designs.

Exclusion criteria

1. Studies not published in English
2. Studies not focused on health professions
3. Studies not focused on occupational stress and coping

Table 1: List of electronic databases searched and articles retrieved

Electronic databases	Number of items with combined search terms	Number of articles retrieved (met inclusion criteria)
CINAHL	284	81
Medline	169	79
PsycINFO	295	130

3.2 Overview of the literature on occupational stress

An extensive search of the literature relating to occupational stress experienced by MSWs/MWAs revealed only a very limited number of specific research articles and policies. Furthermore, articles about the Nigerian population were very limited. A considerable amount of literature related to other healthcare workers (professionals), including midwives in developed countries was found (Carlisle et al. 1994; Flanagan and Flanagan 2002;

Dickinson and Wright 2008). Also, noted was the range of tools used within these studies to measure occupational stressors among healthcare staff, including the Occupational Stress Indicators (OSI), Nursing Stress Scale (NSS), and General Health Questionnaire (GHQ 12). Further examination revealed that the literature focused on the effects of continuous exposure to stressful situations including emotional labour, role conflict and heavy workload (Chang et al. 2007; Lim et al. 2010). The search identified a gap in the literature on MWAs and stress and, provided a strong indication that further research was required.

Therefore, to provide a context and evidence base for the study, literature from other health professions including nursing was explored given the limited focus on the maternity services and MWAs in Nigeria. Similarly, research conducted in developed countries was utilised, due to the limited literature available about the Nigerian healthcare workers or maternity services. This approach helped to identify the factors that caused occupational stress and its effects on the health and well-being of individuals. In addition, the literature provided details of the coping mechanisms used and levels of resilience evident among healthcare professionals (HCPs). Themes from these studies were used to identify potential hazards and threats to the health and well-being of MWAs working in a maternity care setting. The researcher was aware that the literature reviewed focused on healthcare roles that differ from those of the intended research population (MWAs), thus preventing a like-for-like comparison. Hence, caution was required when interpreting or generalising such studies due to the variation in role and function of the nurse-midwife as well as environmental and cultural differences in developed countries. It is with this caveat in mind that the researcher reports findings related to nurses and occupational stress to MWAs, in an African context. Also, since there were no studies of occupational stress and coping in relation to MWAs, who are the focus of this study, it was important to understand whether these wider findings were applicable.

3.3 Meaning of stress and theoretical concepts of stress

Stress has been defined in several ways, with some overlap but no evidence of convergence toward a common definition. In the 17th, Century, the word ‘stress’ was attributed to hardship, straits, adversity or affliction (Hinkle 1974). The concept of stress was further developed and by the 19th Century, stress was considered as a basis for ill-health (Lazarus and Folkman 1984).The concept of stress has been defined and researched from four main perspectives: as a stimulus, as a response, as an interaction between the stimulus and response and as a transaction (Dewe et al. 2012; Jain et al. 2013). These perspectives have provided the existing theories on stress, which contributed considerably to the body of knowledge on the nature and characteristics of different individual interactions within the work environment (Colligan and Higgins 2006; Dewe et al. 2012).

Cox and Griffiths (1995) stated that there are three major conceptions of stress: the engineering approach, where stress is understood as a stimulus or environmental characteristic; the physiological approach, where stress is viewed as a physiological or biological change that occurs during exposure to stressful situations, and, the psychological approach, where stress is not conceived of in terms of a stimulus or a response but as an interaction between the individual and the environment. These approaches are similar to the main perspectives identified by Jain et al (2013). However, the psychological perspective is considered more important than the engineering and physiological approaches due to its focus on individual elements in conceptualising stress (Cox and Griffiths 1995).

Stress is generally attributed to physiological and psychological reactions to certain events in the environment (Jain et al. 2013). According to Selye (1978), stress is the nonspecific response of the body to any distressing circumstances or demands made on it. Lazarus and Folkman (1984: 21) defined stress as, ‘a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being’.

These various definitions have resulted in different theories of stress and coping. Cannon (1932) and Selye (1978) noted the link between stress and physical health. Other stress theories outlined in the literature include, Lazarus and Folkman's (1984) transactional theory of stress and coping, Karasek (1979) job demand– control model (JD-C model), Karasek and Theorell (1990) demands–control- support (DCS) Model and Siegrist (1996) effort–reward imbalance (ERI) model. However, the two most influential models/theories used to explain stress within the healthcare setting are Karasek's job demand–control model (Karasek 1979) and Lazarus and Folkman's transactional theory of stress and coping (Lazarus and Folkman 1984). These models are summarised below.

3.3.1 Fight-or-flight and General Adaptation Syndrome theories

Cannon (1932) claimed that stress is a response to environmental factors or stressors and highlighted the fight-or-flight reaction. According to Cannon (1932), the human body is made up of internal mechanisms that enable it to function and maintains equilibrium or homeostasis. Thus, when the human body is exposed to environmental factors it reacts in an attempt to adapt to different physiological systems, in a bid to compensate. Selye's (1978) work is a continuation of Cannon's (1932) theory of stress (Hobfoll 1989). Selye (1978) contends that stress is a response to a state manifested by a syndrome consisting of all the non-specifically induced changes within a biological system. This response is what Selye (1978) expanded on in his work and described as the General Adaptation Syndrome (GAS). There are three main stages within the GAS. The first is the alarm reaction stage, which comprises of an initial and a counter shock phase. Then the shock phase exhibits an increased adrenaline discharge and gastrointestinal ulcerations while the countershock phase initiates a defensive process characterised by increased adrenocortical activity. The resistance stage: at this point, the symptoms of the alarm phase fades, indicating an adaptation to the stressors while the exhaustion stage marks the phase when aversive stimulations persist with resistance giving way to exhaustion (Selye 1978).

Although Selye's (1978) theory of stress has been influential, it has been criticised for its lack of ability to identify the psychological effects of stress and/or individuals' ability to deal with stressful situations and explaining stress mainly in terms of outcome (Hobfoll 1989). This implies that there has to be an outcome before an individual can conclude that a stressful event has occurred. Hence, Selye (1978) failed to identify specific mechanisms that may explain the cognitive transformation of objective harmful events into subjective experiences of distress (Lazarus and Folkman 1984).

3.3.2. Person-Environment Fit theory

The Person-Environment (P-E) fit theory, developed by French et al. (1982), is another widely used model that has underpinned analysis of stress (Dewe et al. 2012). The main premise is that stress does not solely arise from a person or an environment separately, but from a fit or congruence between the person and environment (Edwards et al. 1998). The interaction between the person and environment are conceptualised as important factors to understanding a person's cognitive, affective and behavioural reactions (Dewe et al. 2012). Therefore, this theory was viewed mostly as a psychological phenomenon whereby the effects of P-E fit require an individual to be aware of their fit with the environment. Hence, occupational stress is characterised within the P-E fit theory as a misfit between a person's abilities or values and environmental (occupational) demands and supplies. This misfit leads to deleterious psychological/physiological effects (Mark and Smith 2008).

There are three main divisions/ distinctions to the P-E fit theory that are used in research (Edwards et al. 2006b). The first and primary division exists between the person and the environment. This is a prerequisite for the conceptualisation of the P-E fit and provides the basis for examining the reciprocal causation between the person and the environment. The second division is between the objective and subjective representations of the person and the environment. French et al. (1982) explained this division as that the person and environment can be described both objectively and subjectively. This implies objective person (P) and environment (E) refers to these variables as they exist independent of an individual's perceptions, while the subjective

P and E refers to variables as they are perceived by an individual (Edwards et al. 1998; Edwards et al. 2006b). The third division is between environmental demands and a person's abilities and the match between a person's needs (motives and values) and environmental supplies (rewards).

A combination of the first two divisions has resulted in four types of correspondence between the constructs of Person and Environment:

1. Objective P-E fit:
2. Subjective P-E fit
3. Contact with reality establishing the degree of correspondence between the subjective and objective environment.
4. Accuracy of P-E fit self-assessment representing a match between the objective and subjective person.

The implication of these divisions for an individual's health is that a minimal discrepancy between the four correspondences is an indication of good mental health. Objective P-E fit is recognised to have minimal impact on mental health unless it is translated into subjective P-E fit that can lead to decreased well-being (Edwards et al. 2006b).

In summary, the concept of P-E fit theory identifies how a combination of the relevant person and environment constructs can contribute to occupational stress. Thus, increased physiological strain and decreased psychological well-being are the two major outcomes of misfit within an occupational context (Edwards et al. 1998; Dewe et al. 2012). However, despite the contribution of the P-E fit to the body of research and its wide spread recognition, it faces a major criticism for its lack of appropriate conceptualisation of the environmental (E) component within the theory (Dewe et al. 2012).

3.3.3 Effort –Reward Imbalance Model

The ERI model is another theory that is widely used in the field of occupational stress. This model was developed by Siegrist (1996) with a focus on the role of work stress in the development of cardiovascular risk and disease. The key concept within this model was social reciprocity (Mark and Smith 2008). According to Peter and Siegrist (2000), lack of reciprocity, that is a mismatch

between effort at work and suitable reward, leads to stressful experiences. Reward within this model is explained by key parameters including money, esteem, career opportunities (promotion) and job security (Mark and Smith 2008). On the other hand, it is proposed, effort is composed of two main components:

- Intrinsic effort, which is characterised/described as personal motivation or coping behaviours, such as over-commitment. Within the ERI model over-commitment refers to an individual exhibiting a set of attitudes or making excessive efforts promoted by a strong desire to meet unrealistic goals at work.
- Extrinsic effort is attributed to organisational or external pressures such as workload.

Hence, the ERI model proposes that effort is expended at work as part of an organised process of exchange to which society contributes in the form of rewards (Peter and Siegrist 2000). This implies that effort expended by employees is reciprocated by equitable rewards from their employers (Peter et al. 2002). Furthermore, this model proposes that when there is failed reciprocity, high efforts (cost) but low reward (gain), strong negative emotions and associated stress reactions can occur with adverse long term health consequences for individuals (Siegrist 2010). Bøggild and Knutsson (1999), Byrne and Espnes (2008) and Akanji (2013) support the principles of the ERI model and identified that individuals exposed to high effort-low reward work situations are at greater risk of cardiovascular disease than those in low-effort and/or high rewards work situations.

In summary, the ERI model expands on Karasek's (1979) JD-C model of stress by pointing to a broader socio-economic meaning of work that includes features such as job security, career opportunity and salary. In addition, it incorporates both extrinsic/organisational (stressors) and intrinsic/personal (coping) elements to explain the concept of stress. This is in contrast to the JD-C model which excludes the dimension of individual (personal) coping (Peter et al. 2002). Furthermore, while the job strain model focuses on extrinsic factors, individual difference is recognised within the ERI model. This identifies

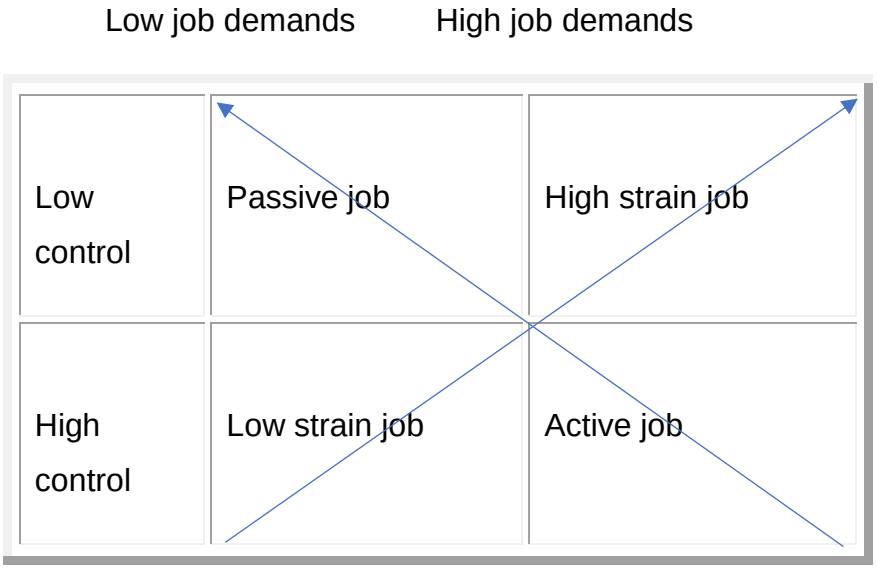
the role of subjective perceptions that result from a variation in individual ability and capability to determine the perceived mismatch between effort and reward (Siegrist 1996). Although the ERI model recognises the role of individual difference and subjective perceptions of the environment, the practical implications of this are not well developed within the model (Mark and Smith 2008).

3.3.4. Demand – Control- Support theory

Perhaps the most widely used model within occupational stress research is the model/theory developed by Karasek (1979), called the Job Demands-Control (JD-C) model. Karasek (1979) also used the word 'discretion' as a synonym for control in this model. This model focuses on two psychosocial characteristics, job demands and job control (Mark and Smith 2008). Job control (also referred to as decision latitude) is comprised of sub-factors: decision authority and skill discretion (opportunities to use learnt skills). Karasek (1979) proposed that although job demands (physical and psychological) can impact on levels of stress, these demands are not the main reasons. The level of strain people experience at work is determined by the level of control (if any) they have over demands. Hence, the main premise within this model is that control will buffer the effect/impact of work demands on stress levels (Karasek 1979). The different relationships between the two components (job demands and job control) are defined by four types of jobs (Karasek 1979). These jobs are summarised below and illustrated in Figure 4:

- Active job: when demands and control are simultaneously high, which leads to the development of new behavioural patterns on/off the job
- Passive job: demands and control are simultaneously low. According to Karasek (1979), this induces a decline in overall general and problem-solving activity.
- Low strain job: low demands and high control
- High strain jobs: the most stressful type of job where individuals experience high demands and have low control over demands such as workload.

Figure 4: Job demands- control model



Adapted from Karasek (1979).

Karasek (1979) proposed an interaction between demands and control, when demands are high and control is low, a high level of strain develops and is likely to lead to negative health outcomes. However, this model was expanded to include social support as evidence suggested that support may act as a buffer in high-demand conditions (Karasek and Theorell 1990). Karasek and Theorell's (1990) demand – control-support (DCS) model has been found to predict various physical and psychological outcomes, including depression and heart disease in nurses (Van der Doef and Maes 1999; Weyers et al. 2006). Therefore, the DCS model predicts that individuals exposed to high levels of work demands and low levels/a lack of support and job control (from sub-factors of decision authority) are likely to experience negative health outcomes (Mark and Smith 2008). However, despite the inclusion of support, the DCS model is limited in terms of the range of job features it considers and therefore may not appropriately reflect the current dynamic multi-stressor nature of workplaces (Mark and Smith 2008). In addition, the model does not take into consideration individual differences in explaining levels of exposure to stressors (Dewe et al. 2012). Hence, the universal application of this model to research has been controversial.

3.3.5 Stress and Coping theory

Lazarus and Folkman's (1984) theory of stress and coping is mentioned as the most theoretically influential transactional theory within the stress literature (Perrewé and Zellars 1999). This model is also referred to as the cognitive-relational or phenomenological approach to stress (Mark and Smith 2008).

According to Lazarus and Folkman's (1984) theory of stress and coping, stress occurs when there is a perceived (appraised) discrepancy between the demands of a situation and the resources the individual (e.g. the MWA) has available to deal (cope) with the situation (e.g. support). Mark and Smith (2008) argue that this theory of psychological stress and coping identifies the dynamic relationship between the individual and their environment. This approach describes stress as the psychological and emotional state that is internally represented as part of a stressful transaction. Thus, this theory provides the transactional definition of stress. Transaction within this theory implies that stress is located neither solely in the person nor in the environment (Dewe et al. 2012). Hence, the fundamental proposition within the transactional theory (model) is that the interaction between a person and the environment results in the stress felt by an individual (Perrewé and Zellars 1999). The two central mediators within this theory are cognitive appraisal and coping (Perrewé and Zellars 1999).

The concept of cognitive appraisal is the process that binds the person and the environment within a transaction, leading to a relational meaning being constructed by a person (Lazarus 1999). It is this relational meaning that is central to the stress process. An appraisal is a conscious process that offers a causal pathway to link those discrete emotions that best describes the nature of an individual's stress experience (Cox et al. 2000; Lazarus and Cohen-Charash 2001). Two types of appraisal are central to this model: primary and secondary (Lazarus 1999). Lazarus and Folkman (1984) described how a person evaluates a stressful situation in relation to its potential personal relevance and significance in terms of its impact on well-being. This process is termed primary appraisal and plays an important role in the coping process. It is at this stage that an individual identifies what is at stake, considering the

significance of the encounter and evaluating it in terms of personal meaning (Lazarus 1999). Lazarus (1999) identified three types of evaluation.

1. An irrelevant encounter, one that has no personal significance for an individual and is mostly ignored.
2. A benign-positive encounter is one that is evaluated as beneficial and/or desirable.
3. A stressful encounter is evaluated as harmful, threatening or challenging.

Hence, these different situations are appraised as involving harm/loss, threat or challenge to an individual's well-being. These are the three types of primary appraisal (a fourth identified as benefit) which serve as a cognitive underpinning for coping (Lazarus and Cohen-Charash 2001). This marks the beginning of a process where an individual focuses on what can be done about a perceived harm, threat or challenge by evaluating available coping resources. Lazarus and Folkman (1984) transactional model proposed this to be secondary appraisal. This involves evaluation of a situation and level of control whereby different stress appraisals can lead to various coping strategies**.** Within this model, coping is seen as a process fundamental to how people interact with the environment. This is an ongoing process that occurs as the individual and situation demands (Cheng and Cheung 2005).

Thus, the transactional model depicts coping as a choice informed by the primary and secondary appraisal of an encounter or situation (Perrewé and Zellars 1999; Dewe et al. 2012).

Coping is defined as 'cognitive and behavioural efforts to manage (master, reduce or tolerate) a troubled person-environment relationship' (Folkman and Lazarus 1985: 152). Folkman and Moskowitz (2004) also described coping as the thoughts and behaviours used to manage the demands of a situation (internal or external) that is appraised by an individual as stressful. Coping is expected to be consistent with the perception and determination of whether anything can be done to effect a change in the situation. Hence, an individual's choice of coping method is determined by their perceptions of control over their stressful situation (Perrewé and Zellars 1999). Thus, the outcome of

coping depends partly on the fit between the appraisal and the coping methods applied (Folkman and Lazarus 1980). Therefore, failure to cope successfully with a situation due to either excessive demands or lack of resources leads to stress and negative health outcomes (Cox et al. 2000).

Folkman and Lazarus (1980) identified two types of coping: problem-focused (facilitates adapting to external demands or managing encounters) and emotion-focused coping (facilitates adapting to emotional demands or regulating emotions in a distressed state). However, despite the distinct classification, researchers claimed these are too narrow and require further refinement to take into consideration the various coping strategies used by different individuals. Folkman and Moskowitz (2004) regarded these classifications as a broad brush account of coping distinctions. Thus, a different category of coping was identified: 'meaning-focused coping'. Meaning-focused coping, in essence is appraisal based coping, when a person draws on personal beliefs, values and existential goals to motivate and sustain coping and well-being during a challenging situation (Folkman 2008). This occurs when the original model of appraisal has had an unfavourable outcome after an emotion reappraisal process, leading to chronic stress (Folkman 2008). At this point situations that are not favourably resolved trigger the need to 'try again', leading to meaning-focused coping. Thus, cognitive strategies are used to manage the meaning of such situations. Dewe et al. (2012) suggest that classifications of coping strategies do not identify their effectiveness but how they are used in particular situations provides a clear justification for categorisation. Hence, two theoretical approaches that offer an understanding of the most appropriate way to judge the effectiveness of coping methods have been identified. The first approach focuses on whether personally significant and appropriate outcomes have been achieved, while the second focuses on the fit between the type of coping used and the nature of the encounter (Folkman and Moskowitz 2004).

The transactional model of stress (Lazarus and Folkman 1984) has been widely supported by researchers, including Payne (2001). This model has been instrumental in demonstrating the way people evaluate situations and their methods of coping with respect to their health and well-being.

Although Lazarus and Folkman's (1984) transactional theory can explain individual differences in experiences of and reactions to stress, it is unable to identify stressful aspects of the work design (environment). However, the flexibility of the model, which focuses on the ongoing interactions between the person and their environment, their appraisal process and ability to cope, made it the most applicable for this study. However, despite the appropriate fit of this model with the study, consideration was given to Karasek and Theorell's (1990) demand–control-support (DCS) model.

In summary, Karasek and Theorell's (1990) theory focuses on the point that it is not just workload (demand) that causes occupational stress, but also the inability to control workload and a lack of adequate support can potentially worsen the experience of stress. In this instance, individuals engage in a cognitive appraisal of the occupational situation in evaluating the stressors. Hence, when demands from the work environment exceed an individual's available resources, this could result in occupational stress or a threat to their health and well-being depending on the appraisal. At this stage, the individual will use certain coping strategies to deal with the perceived threat to their health and well-being (Lazarus and Folkman's 1984) transactional model/theory). Therefore, as well as work characteristics, it is important to understand how personal differences may also affect how individuals undertaking MWA roles deal with stressors (if any) at work.

3.4 Occupational stress and midwifery (maternity service)

Some would contend that midwifery can be an emotionally charged profession (Hunter 2001). Midwifery practice is recognised as the care of women and new-borns founded on providing the necessary support and care during pregnancy, labour and the postpartum period (Wickham 2005; Mansfield 2008). Thus, whether the experience of pregnancy and childbirth is positive or negative, midwives and maternity support workers (MSWs/MWAs) are involved in giving care and support for women and their families. Some of the literature suggests midwifery (maternity services) research has focused on the emotional aspects of the profession and that accounts of the experiences of MWAs who work in the same maternity services have not been addressed or

gathered (Hunter 2001; Hunter 2005; Prowse and Prowse 2008; Mollart et al. 2013; Prowse and Prowse 2015). Studies have identified that the emotional work required to achieve the necessary outcomes in midwifery can also prove costly for the psychological well-being of the person performing it (Hunter 2001; Mann 2004). However, despite this, there is still a dearth of literature on occupational stress among midwives compared to nurses, and none about MWAs. This applies not only to the MWA role in Nigeria but also to their counterparts in the UK.

Evidence suggests that health professionals are at significant risk from the negative effects of working in stressful workplaces, including the maternity care setting (Edwards et al. 2000; Kirkcaldy and Martin 2000; Mark and Smith 2012). According to the HSE (2012), the highest rate of occupational stress was reported among health workers (professionals). The major work elements identified as causing occupational stress were work pressure and perceived lack of support from managers (Bradley and Cartwright 2002: HSE 2012; Chan and Huak 2004; Button 2008). Healthcare workers, including MWAs, are particularly at risk of experiencing occupational stress, leading to burnout as a result of continuous exposure to stressors, high absenteeism and staff turnover (Kirkcaldy and Martin 2000; Clegg 2001).

3.5 Sources of occupational stress: a maternity service overview

An array of stressors has been identified within the healthcare literature. Among these stressors are the death and dying of patients, work overload, conflicts with physicians, role overload, infrequent breaks, lack of support, inadequate time to attend to patient needs and staff shortages (Dallender et al. 1999; Healy and McKay 2000; Kipping 2000; Kirkcaldy and Martin 2000; Hughes et al. 2002; Edwards and Burnard 2003; Santos et al. 2003; Stacciarini and Tróccoli 2004; Mojoyinola 2008; Ladan et al. 2014). These stressors varied between regions due to the different operational systems within the healthcare systems, culture, speciality, education and the work experience of healthcare workers (Lee and Wang 2002; Sveinsdóttir et al. 2006). The main categories of stressors identified within the literature will be discussed below, and include workload, staff shortages, professional relationships and work

intensification. Other stressors were associated with the physical work environment, including inadequate staff rest area, excessive noise and poor lighting (Ulrich et al. 2004; Totman et al. 2011; Long et al. 2014). It was observed during the literature review that the majority of these stressors did not occur in isolation but influenced one another.

3.5.1 Workload

Workload is identified as one of the major causes of occupational stress (Chappell and Novak 1992; Kirkcaldy and Martin 2000; Lee and Wang 2002; Garrosa et al. 2008; Li and Lambert 2008). Research shows that as workload increases and work induced stress rises, the rate of staff turn-over also rises (Edwards and Burnard, 2003; HSE 2012). Furthermore, studies show that heavy workloads meant that healthcare workers have limited time to take meal breaks during their shift (Rogers et al. 2004a; Khowaja et al. 2005; Trinkoff et al. 2006; Witkoski and Dickson 2010).

Wheeler and Riding (1994) surveyed a sample of 82 nurses and 42 midwives using a stress inventory and identified four underlying sources of stress, including work overload and time pressure, organisational and management issues, interpersonal conflict and, poor working conditions and facilities. This study found that, on average, work overload and time pressure were the highest stress factors with no major difference between nurses and midwives. While this study was conducted over a decade ago, it identified the need for further research on how coping strategies can be developed to effectively deal with stress. Despite this, stress continues to cause concern within the healthcare setting. Although the findings from Wheeler and Riding (1994) are similar to those of more recent studies by Healy and McKay (2000) and Li and Lambert (2008), care needs to be exercised in using the original study. This is due to limitations in selecting the sample and the tools used differ from those of contemporary studies, which hindered a proper comparison. However, Wheeler and Riding (1994) justification for not using existing common stress measures was due to the variation in regional context. It was a quantitative study and emphasised the need for future studies to use a less structured

approach (specifically phenomenology) to fully understand different sources of stress from individual perceptions.

Calnan et al. (2001) used the General Health Questionnaire (GHQ 12) to ascertain levels of stress among health service workers in general practice. Their findings indicated that a high percentage of nurses were classified as suffering from stress and mental ill health due to high work demands and low control over their job. Although the GHQ 12 as a tool is limited in identifying other stressors, the results were consistent with findings from similar studies in terms of levels of occupational stress experienced by health workers (Kirkcaldy and Martin 2000; Evans 2002). Other studies identified that health workers continually experience high levels of occupational stress with the most common stressors being associated with workload, role conflict and staff shortages (Smith et al. 2000; Lee 2003; Spooner-Lane and Patton 2007). Although these studies identified high levels of stress among nurses, researchers have argued that not all areas of nursing are associated with high levels of stress (Payne 2001; Peters et al. 2013). Hence, the level of generalisation has been disputed by researchers based on the appropriateness of tools used within different contexts.

For instance, a study by Payne (2001) of 89 female nurses and nursing assistants from 9 hospices used a combination of the Nursing Stress Scale (NSS), Ways of coping scale and the Maslach Burnout Inventory (MBI). This study reported a low level of stress and burnout among the hospice nurses. Another cross-sectional survey of 71 Australian nurses by Peters et al. (2013) used a modified NSS tool and also reported a low level of stress overall. However, workload and the death and dying of patients were identified as the main sources of occupational stress. These findings could be an indication that low stress levels exist within this particular group of nurses irrespective of their service specialism or cultural differences. Arguably, this may be due to hospice nurses using more effective burnout prevention/coping strategies than nurses working in other areas (Payne 2001; Bruneau and Ellison 2004).

Conversely, moderate-to-high levels of stress have been noted in nurses working in critical care units (Edwards et al. 2006a; Lim et al. 2010). Although

these studies relied on self-reporting and purely statistical analysis, there may be some lessons to be learnt or strategies that can be transferred from hospice settings to reduce the stress in areas of predominantly higher levels, including the maternity setting. The findings emphasised the importance of not labelling an individual as coping well or badly in relation to stress or burnout and the need to avoid oversimplifying the coping/burnout relationship (Payne 2001). Other sources of occupational stress have been identified by researchers including inadequate support, improper reward systems, lack of communication and inadequate resources (Lee and Wang 2002; Bianchi 2004; Chen et al. 2007).

An overview of sources of stress for nurses in different areas has been given above and includes workload and staff shortages. However, within the maternity setting additional factors can include power dynamics between a midwife and doctors, and time pressures (Carlisle et al. 1994; Evenden and Sharpe 2002). According to Hunter (2001), changes in the organisation of care and emotions in maternity services (midwifery) are potential sources of stress. Variations in the organisation of care, specifically in the NHS and the type of midwifery they were expected to practise have resulted in midwives becoming dissatisfied with the profession. Both role conflict and the ambiguity associated with the organisation of maternity care has left many midwives stressed to the point of leaving (Ball et al. 2002).

Other sources of occupational stress include working long hours. There is growing evidence of the effects of long and non-standard working hours on a variety of health outcomes, including occupational stress. Studies identified that working long hours leads to exhaustion and fatigue, which have an adverse impact not only on the health and well-being of nurses but also on the care and safety of patients (Trinkoff et al. 2006; Said et al. 2015). Workload and staff shortages have led to healthcare staff working longer and extended hours (Rogers et al. 2004b; Keller 2009; Wu et al. 2010). Hoffman and Scott (2003) conducted a study on 500 randomly selected registered nurses in a Michigan hospital and used a descriptive cross sectional survey. The study revealed major factors that contributed to stress among nurses. The majority of the nurses who worked 12 hour shifts experienced more stress than those

working 8-hour shifts. This was further compounded by caring for dying patients and heavy workloads. This was consistent with studies that reported that long working hours contributed to poor staff retention, including for midwives, and impacted on their health and well-being (Wu et al. 2011; Mollart et al. 2013; Yoshida and Sandall 2013).

Staff relationships have been identified as a significant aspect in terms of the effectiveness of maternity services and are therefore key to the quality of care provided to mothers and babies (Evans and Choucri 2012). Professional working relations have been described as a major stress factor among healthcare workers, including midwives, nurses and doctors, despite advocating for multidisciplinary team work (French et al. 2000; Leonard et al. 2004; Alotaibi 2008; Nyssen and Hansez 2008; Hayes et al. 2015). This was mainly attributed to conflict with doctors or fellow nurses, lack of consultation, lack of recognition and input in decision-making process (Payne 2001; Lee 2003; Murphy 2004; Rowe and Sherlock 2005; Rothmann et al. 2006; Spooner-Lane and Patton 2007; Mojoyinola 2008). For instance, Arikan et al. (2007) conducted a study to determine levels of job stress among 180 nurses working in a dialysis unit. A descriptive and cross sectional survey was used and, included the Work-related Strain Inventory (WRSI). The nurses reported that conflicts with physicians contributed to increased stress. This was not limited to communication problems but included verbal attacks from physicians, other nurses, patients and their families. This finding was consistent with other studies conducted among nurses (Lee and Wang 2002; McGrath et al. 2003; Sveinsdóttir et al. 2006). Stacciarini and Tróccoli (2004) surveyed Brazilian nurses working within the public health sector and education system. This study had a large sample size of 461 nurses but a very diverse range of settings making it more difficult to localise the results. Despite this limitation, lack of professional recognition was reported as a general cause of stress among nurses. Findings from Healy and McKay's (2000) study also revealed conflict with other nurses to be a cause of stress; however, this stressor was reported less than workload.

Both lack of resources and high job demands were also listed as causes of stress in several international and national studies (Callaghan 2003; Bianchi

2004; Anyebe et al. 2014). Currid (2008) interviewed eight nurses working on four acute wards within a mental health trust. The nurses identified lack of resources and management leadership style as major causes of stress. Despite the rather small sample size within this study, the findings were consistent with other studies that identified similar stressors within the healthcare setting. For instance, Glazer and Gyurak (2008) conducted a cross cultural study among nurses from five different countries: Hungary, Israel, Italy, UK and the USA. The findings from this study revealed lack of resources to be a major cause of stress among nurses in the five countries, followed by workload and low salaries. Similar findings were reported by Adib-Hajbaghery et al. (2012) and Mosadeghrad (2013). In some instances, the issue of lack of resources included the limited availability of equipment and the lack of precautions to minimise staff's exposure to infections or diseases while caring for patients (Ball and Pike 2008; Jones 2014). For instance, studies have reported the risk of nurses contracting hepatitis C and other diseases from needlestick injury, which often caused anxiety among staff (Sepkowitz and Eisenberg 2005; Trinkoff et al. 2008; Thomas and Murray 2009; Adams 2012).

The issue of low salaries and lack of adequate remuneration has been reported within literature as a source of stress within the health sector. In a study by Alotaibi (2008), these factors were identified by Kuwait nurses to be the main sources of stress. Similar findings were also reported by McGrath et al. (2003), Bianchi (2004) and Glazer and Gyurak (2008). This issue of poor reward and salary has often contributed to nurses experiencing low job satisfaction (Nabirye et al. 2011; Mosadeghrad 2013). With respect to other causes of stress; low job control, lack of support and poor career progression have consistently been highlighted as factors within the literature reviewed (Bakker et al. 2000; Callaghan 2003; McGrath et al. 2003; Farrell et al. 2006; Piko 2006; Sveinsdóttir et al. 2006). For instance, Stordeur et al. (2001) examined the effects of work stressors on emotional exhaustion experienced among 625 nurses at a Belgian university hospital. This study used the NSS tool to measure the most frequent occupational stressors among nurses. The findings revealed that workload and lack of support were the most frequently cited stressors. Although, this study had a low response rate, the findings were

consistent with studies that reported similar results (Healy and McKay 2000; Bartram et al. 2004; McCarthy et al. 2010).

Earlier studies in maternity settings used mainly the GHQ tool. For instance, Mackin and Sinclair (1999) surveyed a population of 45 midwives working in a labour ward of a large maternity hospital in Northern Ireland. The findings reported that one-third of the 45 midwives felt stressed. The midwives indicated that lack of communication, lack of autonomy, inadequate time to complete tasks and the emotional demands of labouring women and their partners as major sources of stress. Although this study was limited by its small sample size, its findings contributed to the body of knowledge and supported the results of earlier studies. Hence, one of the main sources of stress identified by midwives is their working conditions. These are conditions where the job was compared to 'a production line' and where the midwives' inability to respond 'appropriately' or spend enough time with mothers caused occupational stress (Sandall 1997; Prowse and Prowse 2008). A study by Curtis et al. (2006) of midwives conducted in two phases used interviews and questionnaires (28 interviewed and 978 surveyed) to explore the reasons why midwives left the profession. Curtis et al. (2006) identified workplace stress as a key factor that impacted on midwives' physical and mental health and contributed to their decision to leave midwifery. Real or perceived staff shortages, high work demands, lack of control, lack of support and inability to practise the midwifery they wanted (job dissatisfaction) were identified as sources of stress (Curtis et al. 2006). This is supported by Deery (2005), whose study of midwives found evidence of occupational stress and burnout in maternity settings and the importance of devising and mobilising support for midwives in practice. Thus, to remain in the profession, midwives have to devise coping strategies to manage occupational stress as a result of the tension between the physical and emotional demands of the women (new mothers) they care for and the institutions where they work. To further elucidate this problem, the report of the Morecambe Bay investigation (Kirkup 2015) was published in the UK during the early write up of this study. Although the different setting was acknowledged, with minimal possibilities for a like-for-like comparison, the report identified the existence of occupational stress

within the maternity setting and the impact it had on service outcomes (Kirkup 2015).

Similarly, maternity services and the organisation of care in Nigeria have faced several challenges, including lack of adequate facilities and the limited number of midwives graduating each year (AHWO 2008). However, while there is a dearth of literature on occupational stress among health workers in developing countries, including Nigeria, a few studies have been conducted on burnout amongst nurses, but none of them were carried out within the maternity setting and there has not been a focus on MWAs in Africa. The studies conducted have reported occupational stress and emphasised the link between occupational stress and burnout (Lasebikan and Oyetunde 2012). Therefore, to effectively reduce the levels of burnout experienced among health workers the issue of occupational stress needs be adequately researched, specifically in the maternity care setting in Nigeria.

A study conducted in Malawi used the MBI scale to determine the levels of occupational stress related to burnout among maternity health staff (Thorsen et al. 2011). This was a cross-sectional study using a purposive sample of 101 healthcare workers in a district referral hospital, specifically the antenatal, labour, delivery and post-natal units. Although the sample was identified, a full description of the sample composition could not be obtained, hindering the level of generalisation. The findings concluded that burnout as a result of a continuous exposure to occupational stress was higher among maternity staff than colleagues in other areas (Thorsen et al. 2011). This may be attributed to the potentially stressful maternity environment irrespective of the region and identified that more research is required in this area to establish/understand the context of occupational stress in developing countries.

Thus, there is a growing recognition that occupational stress is leading to dissatisfaction among nurses in Nigerian hospitals and this has an impact on their physical and mental health (Mojoyinola 2008). Lasebikan and Oyetunde (2012) conducted the first major study to include the largest nursing workforce in a general hospital in Nigeria using the MBI and the GHQ 12 tools. One of the limitations of this study was that it was conducted in a single hospital in the

South West region. However, a level of generalisation can be made with caution. Findings from this study reported a high incidence of occupational stress related burnout among nurses. A major source of occupational stress identified was the inadequate staff to patient ratio.

Recent studies with healthcare professionals in Northern Nigeria identified the high incidence of occupational stress (Ladan et al. 2014). A study conducted by Anyebe et al. (2014) used a self-administered questionnaire with 273 nurses from different wards in federal and state hospitals in Nigeria, and this supported earlier findings including those of Lee and Wang (2002). Although this was a quantitative study, the findings were similar to earlier studies. Anyebe et al.'s (2014) study reported that most nurses worked under intense stress, citing poor remuneration, lack of opportunities for career progression, role conflict, inconsistent employment policy, poor staffing levels, having to assume responsibilities without recognition and lack of adequate equipment as sources of stress. Ladan et al.'s (2014) research of health professionals, including midwives and doctors, reported similar findings. This study noted long working hours as the major stressor but other stressors identified included heavy workloads, time pressures, staff shortages, poor communication and infrequent rests. In addition, Lasebikan and Oyetunde (2012) reported a higher level of burnout among junior nurses and this was associated with bullying and the increased delegation of duties from senior staff. This supports Gillen et al.'s (2009) findings of bullying among student midwives. However, caution was exercised in reporting this as further research is required in the Nigerian health system to understand such findings.

A high level of occupational stress was also reported to be associated with poor job satisfaction among a population of nurses in Uganda (Nabirye et al. 2011). This study was a cross sectional survey of 321 nurses using an array of statistical instruments, including the Nurse Stress Index (NSI). A similar finding was also reported by Healy and McKay (2000) and Flanagan and Flanagan (2002). Although different tools were used within these studies, hindering a proper comparison, a common conclusion can be drawn that, irrespective of the environment, exposure to high levels of stress results in decreased job satisfaction in health workers.

In Nigeria, midwives are arguably exposed to increased workload and occupational stress due to staff shortages. This has a cyclic effect for MWA, due to the increased delegation of duties from midwives. In addition, non-payment of salaries and poor remuneration within the public sector has also contributed to occupational stress for health staff, including MWAs (AHWO 2008).

The issue of occupational stress, and particularly the problem of recruitment and retention of health workers, especially midwives, has arguably led to poor patient outcomes in Nigeria (AHWO 2008). Furthermore, it exacerbates the challenges of meeting the MDGs, and specifically MDGs 4 and 5 (UNDP 2010). This has now led to a greater reliance on MWAs in a bid to provide the services required within the maternity setting. This situation is not limited to Nigeria, but also occurs in developed countries, including the UK, where 'qualified staff' are substituted with 'unqualified staff' to address staff shortages (Prowse and Prowse 2008). However, there is no research in any of these countries identifying the key role of MWAs and their experiences within the maternity care setting. The paucity of research on MWAs/MSWs was also noted by Sandall et al. (2011).

3.5.2 Work intensification

The issue of work intensification has been discussed in the literature in terms of individuals being increasingly confronted with rising job demands and role-expansion (Green 2004b). Although, some of these changes have been attributed to increased competition and technological changes which brought some advantages for employees, they have not served to alleviate stress, as this continues to rise, according to international figures (HSE 2012). These changes and increased workload have resulted in employees working at high-speed to meet the demands of their jobs (Gough et al. 2014; Willis et al. 2015). Thus, work intensification has led individuals to suffer from varying conditions impacting on their health and well-being, including increased stress (Brown 2012; Boxall and Macky 2014).

Generally, work intensification is described as having more work to do than previously (Willis 2005). In addition, work intensification includes "taking on

more tasks with the same staff numbers or coping with the same or a heavier workload with less staff" (Willis 2005: 256). This includes working longer hours and more intensive work effort or pace (Green 2004a).

A number of factors have been associated with work intensification, including staff shortages and health reforms implemented with limited budgets (Adams et al. 2000). This has resulted in low job satisfaction among nurses due to increased demands and stressful working conditions. Structural and policy changes within hospitals have also resulted in nurses experiencing increased managerial responsibility, and working under intense pressure with greater workloads (McGibbon et al. 2010). Working at an increasing speed, carrying out different tasks simultaneously and facing reductions in the time allocated and taken for breaks all contribute to work intensification (Green 2004b; Roberts 2007). Franke (2015) supported this analysis, contending that work intensification requires extra and continuing mental and emotional resources in order to deal with increased work demands.

Zeytinoglu et al. (2007) administered a survey to Canadian hospital nurses examining work intensification. The New Health Care Worker Questionnaire was the instrument used in this study, and adapted the Health and Work Life Questionnaire. The findings revealed that work intensification was a contributory factor to the nurses' increased job strain and stress levels. The stress experienced in turn reduced job satisfaction (Zeytinoglu et al. 2007). Another study reported heavy workloads due to staff shortages, and National Health Service reforms contributed to the perceived work intensification experienced by the nurses (Doherty 2009). For instance, Hart and Warren (2015) interviewed nurses and found a clear connection between staff shortages and work intensification. The nurses highlighted that staff shortages resulted in increased workload and pressure at work. In addition, nurses were required to have high skill levels and complete tasks that were normally not part of their work (Prowse and Prowse 2008). Furthermore, the findings revealed that work intensification led to high levels of stress and poor work-life balance among nurses. This supports earlier findings (Doherty 2009).

Another study noted that work intensification results in long working hours and a faster pace of work (Willis et al. 2015). As a result, poor staffing levels lead to patient's not being cared for adequately within hospitals and work intensification. Cooke (2006) conducted a qualitative study with nurses from three different trusts in the North of England. This study noted that work intensification led to conflict over working hours, shift patterns and increased pressure as staff had to move frequently between wards to cover the gaps in the health service. This contributed to nurses frequently being stressed, exhausted and experiencing low morale (Cooke 2006). The nurses within the study found that work intensification was the main factor impacting on nursing care as there was not enough time to care for patients adequately. Work intensification also resulted in nurses being faced with conflict between providing required patient-oriented care and fulfilling rising organisational demands (Kirpal 2004; Hart and Warren 2015).

Nurses in Sweden also experienced difficulties in coping with the intensified labour processes and decreased resources experienced within the hospitals, causing them to feel stressed and close to burnout at work (Selberg 2013). The changing working conditions within the Swedish hospital played a major role in the work intensification experienced by the ward nurses. A similar situation exists among midwives in the UK as a result of them taking on some of the doctors' technical and repetitive tasks (Ball et al. 2002). This has contributed to some frustration being experienced by midwives who have taken on extended roles that hinder them from practicing 'woman centred' midwifery (Prowse and Prowse 2008). This can also be linked to Harding's (2013) argument whereby individuals are described as "Zombie machines", resulting in a labour force that only thinks and acts for the purpose of the organisation. Hence, individuals are reduced to their organisational role and opportunities to develop themselves both personally and professionally are restricted, which can lead to frustration and dissatisfaction at work (Harding 2013).

The occupational stress literature has consistently shown that work intensification impairs an individual's health and well-being (Franke 2015). According to Kubicek et al. (2013) work intensification was related to high

levels of emotional exhaustion among a group of health workers caring for older adults, including nurses and nursing aides. Similar findings were reported by Schaufeli and Bakker (2004). They found that there was an increased need for an accelerated pace of work because meeting increased job demands required a sustained effort. This impacted negatively on an individual's health, both cognitively and physically. Kubicek et al. (2013) explained further that when an individual is confronted with work intensification, there is a great need to mobilise mental and physical effort, which often leads to exhaustion and eventually burnout. Kubicek et al. (2013) also noted that care workers confronted with high levels of work intensification have a strong tendency to react negatively to emotional and physical demands due to having fewer opportunities to take a break or recover from demanding situations at work. These findings are similar to those of Selberg (2013).

The issue of work intensification is also applicable to the support worker whose role is being continuously expanded to take on a wider range of tasks (Kessler et al. 2006). This is similar to the case of MSWs taking on more midwife delegated duties, thus increasing the pressure on their role (Lindsay 2004; Hussain and Marshall 2011). Furthermore, Doherty (2009) noted that HCAs also experience role expansion due to staff shortages, as nurses delegate more tasks or devolve bedside nursing to unregulated and or support roles. Davies (1995) argued that enlarging the nurses' scope of practice added to nursing's already broad jurisdiction, arguably creating work intensification rather than empowerment. This was exacerbated by the increased delegation of tasks to nurses due to the reduction in junior doctors' hours in line with the European Working Time Directive, increased throughput and patent dependency (as patients go through the system sicker and quicker) and expanded roles as nurses take on more 'hands on' medical care (Cooke 2006). This contributed to the nurses' perception that their increased workload resulted in work intensification rather than empowerment (Doherty 2009). Willis (2005) also argued that work intensification is not limited to nurses as it has a follow-on effect, impacting on the work of other workers, including cleaners and HCAs. This emphasises the extent of role expansion experienced within the healthcare setting, which is by no means limited to the

nurse's role (Armstrong 2006). This is a situation that has contributed to low job satisfaction among healthcare staff (Chang and Hancock 2003). Thornley (2008) reported a similar concern about the intensified support worker role and presented a clear picture of this idea being engaged with extended clinical/nursing tasks. Hence, the HCAs/Support Workers often felt their role was being used to substitute when unsafe staffing levels prevailed. Consequently the HCAs noted that they were overworked, which contributed to their low morale and willingness to leave their job (Thornley 2008).

It was evident from the literature reviewed that the majority of studies used both qualitative and quantitative methodologies. These studies were mainly conducted in Europe, Canada, Australia and the USA, highlighting the need for more research outside developed regions. However, it was concluded that irrespective of location, work intensification was growing and there is evidence that it increases occupational stress and impacts negatively on the health and well-being of health workers, including MWAs (Willis 2005; Hart and Warren 2015). Furthermore, there was a general perception that healthcare staff are required to take on more work to meet the hospitals' and patients' demands, with fewer resources; that is doing more with less, thus making the job more stressful. Hence, nurses face continuous and increasing workload challenges, mainly due to staff shortages and extensions to their roles which impacts negatively on MWAs. Based on these findings the issue of work intensification is seen to be related to increased health hazards, both physical and mentally. Despite this growing evidence, the voice of the HCA was relatively silent and none of the research focused on the MSW/MWAs, as noted earlier. This emphasised the need for more research to include this under-represented group of healthcare workers who work in the same settings as the midwives that experience work intensification as well as other stressors.

3.6 The effects of occupational stress on health and well-being

Occupational stress was reported to be the largest work related health problem in the UK and globally, particularly among the care giving occupations (Cottrell, 2001; Health and Safety Executive, 2012). This has far reaching consequences, impacting not only on caregivers 'health and well-being, but

also on their ability to accomplish tasks and provide quality care (Edwards and Burnard 2003).

Evidence drawn from various studies has shown the extent to which occupational stress can cause unusual and dysfunctional behaviours, including poor eating habits, smoking and drug abuse, contributing to poor physical and mental health (Edwards and Burnard 2003; McVicar 2003). Continuous exposure to a large number of such stressors, including conflict with other professionals, high workloads, and in some cases dealing with death (maternal/perinatal death) can lead to more detrimental effects on health and well-being (Gardner 1999; Payne 2001; McVicar 2003). These are the circumstances that have continually been attributed to the healthcare profession.

3.6.1 Psychological/mental effects of stress

Occupational stress is known to negatively affect an individual's health and well-being (Nabirye et al. 2011). It was noted that individuals react to occupational stress in different ways both physically and mentally, with a resultant effect on their job performance. Studies have identified different psychological effects of stress including anxiety, mood disturbance, frustration and numbness (Healy and McKay 2000; McVicar 2003; Weyers et al. 2006). A recent study of primary care workers revealed that nine in ten find work life stressful, which was significantly higher than the wider UK workforce (Mind 2016). The psychological impact of occupational stress on these workers was significant, as two in five noted they had considered resigning while one in five developed mental health problems, one in ten had suicidal thoughts and eight in ten experienced physical health issues (Mind 2016).

Stress produces different emotional reactions which range from exhilaration, when a situation is considered stressful but controllable, to discouragement and/or depression when a situation seems unmanageable (McVicar 2003). For instance, Geiger-Brown et al. (2004) conducted a cross sectional survey among 473 US female nursing assistants working in a care home. A combination of stressors was reported in this study, including long shifts with a minimal number of breaks. Exposure to such stressors led to the majority of

the nursing assistants experiencing increased risk of mental health, specifically depression. Although this study used a sample drawn from one region of the USA and self-reported data, the results provided a valuable insight into the psychological effects of stress, which confirmed the findings of earlier studies. Continuous exposure to stressful conditions may cause a range of emotional responses based on an individual's coping efforts (Cox et al. 2000). Gelsema et al. (2006) noted that cognitive impairment could be an early sign of stress when an individual struggles to organise logical thoughts or concentrate, leading to deterioration in the quality of work. This could then move to another stage, such as indifference, or inability to communicate effectively with staff or patients, possibly resulting in staff/patient conflict (Spinetta et al. 2000). Furthermore, this can result in burnout when there is continuous exposure to occupational stress over a prolonged period with little likelihood of improvement (McGrath et al. 2003). For instance, a study conducted among nurses working at a university hospital in Germany noted effort-reward imbalance as a stressor experienced within the hospital (Bakker et al. 2000). This led to the nurses feeling emotionally drained and experiencing depleted personal accomplishments.

Burnout is characterised by depersonalisation, emotional exhaustion and a perception of a lack of personal accomplishment (Maslach 2003). All these can directly contribute to absenteeism and decreased work performance (Maslach et al. 2001). Payne (2001) described burnout as a syndrome that is an outcome of a prolonged process of attempting to cope with demanding stressors, culminating in the exhaustion of personal resources. This was supported by findings from Hunter's (2005) study. Therefore, consistent with other occupations in the health care sector, stress is a common characteristic.

Additionally, one of the findings reported from a study conducted among nurses in a dialysis unit, was the feeling of helplessness due to work stressors (Arikan et al. 2007). This was similar to other psychological experiences of stress reported within the literature noted above, including Hinno et al. (2012).

3.6.2 Physical and behavioural effects of stress

The literature has shown that stress can also cause the body to respond innately to stress by initiating a complex sequence of events, such as an increase in metabolism in preparation for expending more energy on certain physical actions (Donovan et al. 2013). Among the findings of studies identified earlier, physical effects of stress ranging from somatic conditions to life threatening health outcomes have been reported (Arikan et al. 2007; Kelloway et al. 2008; Wu et al. 2010). Physiological responses to stress involve initiating or regulating body processes to adapt or cope with a perceived stressful situation (high work demands) (McEwen 2007). The physical capacity to perform a job is determined mainly by musculoskeletal, cardiovascular and other regulating bodily systems (Chandola et al. 2008). However, both work-related factors (e.g. type of work and workload) and individual characteristics (e.g. health conditions and age) can modify an individual's functions and work performance (Leka et al. 2012). Although there has been a focus on the psychological and behavioural implications of occupational stress, there is an effect on physical health, including migraines, body aches and pains, musculoskeletal disorders and hypertension (Chang et al. 2006; Elfering et al. 2006; Trinkoff et al. 2006; Mojoyinola 2008; Moustaka and Constantinidis 2010). Consequently chronic health conditions, including cardiovascular disease have been attributed to occupational stress (Cottrell 2001; Byrne and Espnes 2008).

Furthermore, it has been reported that when individuals are stressed, they engage in behaviours that undermine the body's attempt to fight any illness by either having a poor diet or disrupted sleep patterns (Donovan et al. 2013). Other behavioural effects of stress include drug and alcohol abuse, smoking, mood disturbance, taking anger out on innocent people, feeling unmotivated and being withdrawn (Pikó 1999; Edwards et al. 2000; Moustaka and Constantinidis 2010; Mind 2016).

Researchers have also identified the effect of stress on the social lives of healthcare workers. This mainly led to family conflicts and staff spending less time with family. Bach and Edwards (2013) noted that time spent participating

in work activities inhibits the fulfilment of family obligations and responsibilities. A major catalyst for this is stress from time based pressures, such as long working hours. A study conducted among personnel in a public hospital in Zurich noted that stress was highly associated with staff work-life imbalance (Hämmig et al. 2012). The healthcare workers within this study, including the nursing staff, reported that they spent large amounts of time at work, which was often accompanied by low reward, which in turn was actually more stressful than job demands. This study was a cross- sectional survey conducted within one hospital and with a broad sample size, which limited generalisation outside this sample. Despite the study limitations, it provided valuable insights into the effects of stress due to working beyond required hours and low reward, keys factors of stress that were highlighted above. These findings were also supported by other researchers, including Demerouti et al. (2004), Hammer et al. (2004), Montgomery et al. (2006) and Sprinks (2013). Similar findings were also found among nurses in a mental health trust, who experienced a poor balance of work and home lives (Currid 2008). This poor work-life balance among staff was attributed to stress from heavy workload, poor staffing and the inability to acess flexible working arrangement (Brooks and Anderson 2004; Fleetwood 2007).

The issue of work-life balance has become more severe as high job demands physically and/or emotionally drain an individual, thus limiting the resources available to meet non-work/family demands, which creates a negative spillover effect (Demerouti et al. 2004). Furthermore, the increasing need for healthcare staff to work long hours has reduced the time and energy available to engage in social or family activities which impacts on the work-home interface (Tone Innstrand et al. 2008). An additonal factor to the issue of stress and poor work-life balance was not only working conditions and lack of work-life balance practices, but also the long commuting hours staff have to make to work (Redmond et al. 2006). Thus, studies have argued that such poor work-life balance has contributed to the growing impact on the health and well-being outcome of an individual (high job stress) and on retention of staff (Valcour 2007; Fereday and Oster 2010).

The effect of high levels of occupational stress has also been identified among nurses and healthcare professionals in Nigeria. Both Ladan et al. (2014) and Anyebe et al. (2014) discussed the physical and mental effects of high levels of occupational stress that include headaches, muscles cramps and high blood pressure. Among the mental and emotional symptoms presented were disorganised thinking, anger, frustration, low motivation and irritability, having limited time to spend with family and sometimes withdrawal (Mojoyinola 2008; Ladan et al. 2014).

Although some interventions that reduce workplace stress and burnout have been identified, such as supervision and co-worker support, there is still some weakness in implementation across professions (Edwards et al. 2006a)

3.6.3 The impact of stress at organisational level

It can be argued that occupational stress has an effect not only on the health and well-being of individuals, but also on organisations in terms of low productivity and high staff turnover (Nabirye et al. 2011). High rates of labour turnover have characterised the maternity service in Nigeria, with a cyclic effect of increased workload for the remaining midwives and even more work delegated to MWAs (AHWO 2008). The situation is not dissimilar in other developed countries. Also, it was noted that occupational stress negatively influences job satisfaction and job performance, resulting in a lack of coping and reduced mental well-being in health workers (Healy and McKay 2000; Kirkcaldy and Martin 2000). Thus, this has resulted in a higher likelihood of staff leaving their jobs, impacting negatively on staff retention. This was supported by researchers, including Nabirye et al. (2011).

The available statistics have also shown that the impact of occupational stress on organisational productivity and working days lost has become costly over recent decades. It was reported that occupational stress cost UK industry £6.7million in lost revenue in 2002, and in 2005/2006 it cost in excess of £530 million, with almost 10 million days lost due to staff going off sick (Health and Safety Executive 2002; European Agency for Safety and Health at work 2009). More recent data showed that sickness absence caused by stress and anxiety increased to 15.2 million days lost in 2013 up from 11.8 million days in 2010

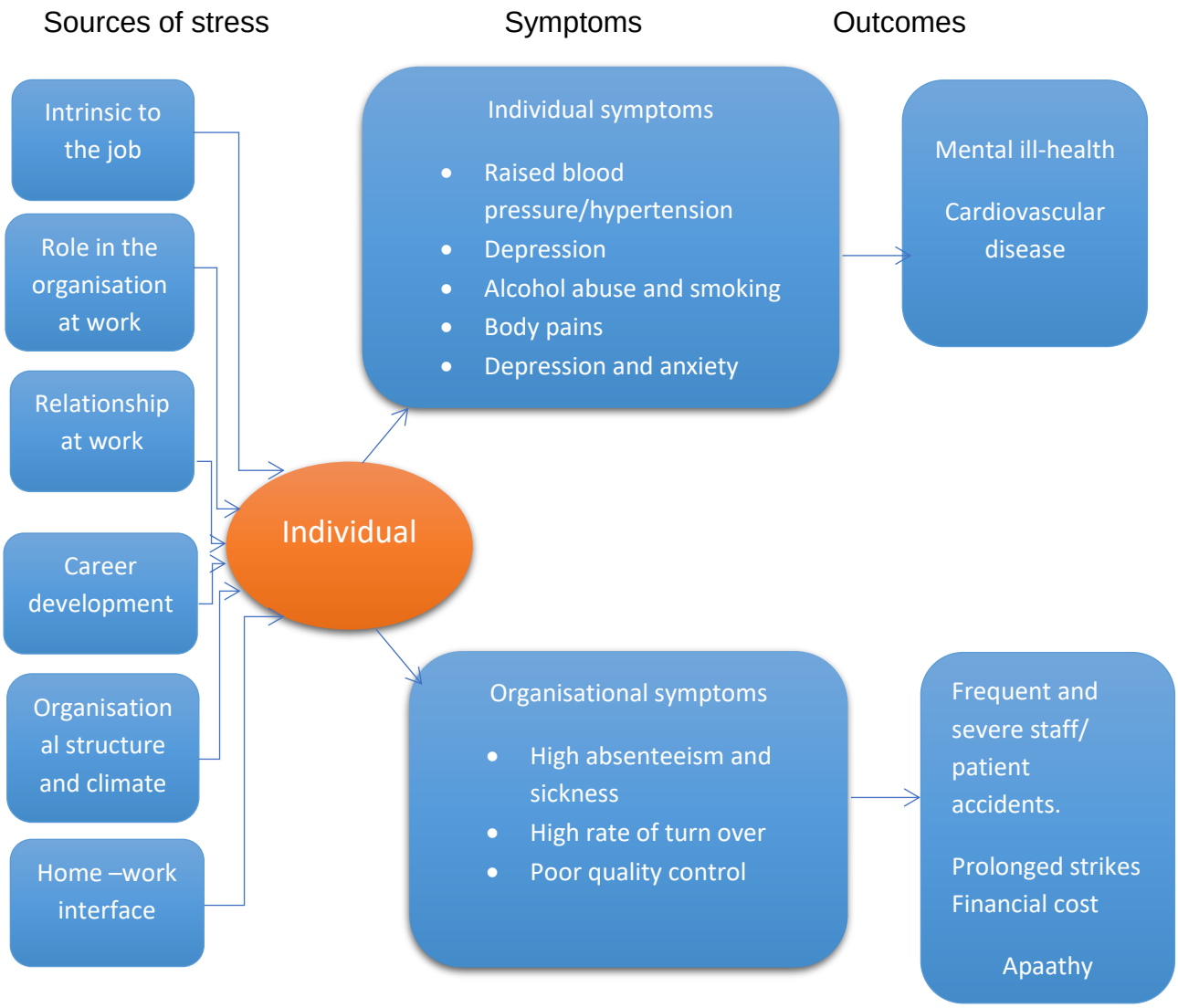
(Health and Safety Executive, 2014). However, there are currently no statistics about the financial cost of occupational stress in Africa and specifically Nigeria, but arguably the cost to Nigerian society is as enormous as the cost to working individuals.

Studies have also identified other effects of occupational stress, including risk to patient safety and reduced quality of care (Needleman et al. 2002; Sveinsdóttir et al. 2006). For instance, a study by Berland et al. (2008) conducted among 23 nurses from 2 hospitals in Norway reported on the effects of occupational stress for patient safety. Themes from this study identified that patient safety was at risk when staff were stressed, due to the increased chances of errors and inappropriate decisions being taken. Participants within this study reported high workload, limited control over work pressures and lack of support as the main causes of stress. This supports Karasek and Theorell's (1990) theory of stress. Although this study used focus groups as a method of data collection, this could have limited participants' freedom of expression thereby hindering the amount of data that could be generated. However, themes identified by this study highlighted the impact occupational stress can have, not only on the health and well-being of staff but also on potential risks to patients (mothers) in their care. Although, research on occupational stress and patient safety is still growing, this finding supports the work of Elfering et al. (2006). These findings could be applied to the Nigerian healthcare system as staff shortages could impact negatively on patient care and safety (Sveinsdóttir et al. 2006).

Other organisational effects of stress include presenteeism (Cox et al. 2000). This involves working while ill (Crout et al. 2005; Johns 2010). Letvak et al. (2012) examined nurses working in hospitals in North Carolina and reported that stress related depression and body pain were significantly associated with presenteeism. This study was a cross sectional survey of nurses that used self-reported tools. Although the limitations of using such an approach were noted, this study drew a vital conclusion on the importance of improving health and well-being among the workforce, not only to reduce ill-health but also to enhance patient safety and the quality of care. This finding was supported by other studies, including Demerouti et al. (2009) and Martinez and Ferreira

(2012). Letvak et al. (2012) also noted that the issue of presenteeism was exacerbated by hospitals offering quarterly bonuses for unused sick time and taking rates of absenteeism into consideration during annual performance reviews. Figure 5 summarises the sources and effects of stress on both the individual and the organisation.

Figure 5: Summary of sources and effects of stress.



Adapted from Cox et al. (2000)

3.7 Coping with stress and resilience

The concept of coping is inextricably linked to occupational stress. Lazarus and Folkman (1984: 191) defined coping as 'the cognitive and behavioural efforts made to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person'. The transactional model of stress and coping has been central to explaining coping outcomes within research (Perrewé and Zellars 1999). The process of appraisal within this model (primary and secondary) focuses on the coping resources available for altering the perceived threat to an individual's well-being (Lazarus and Folkman 1984). This model was supported by several researchers, including Healy and McKay (2000) and Lambert et al. (2004).

According to Folkman and Lazarus (1980), there are different methods for coping, such as problem-solving, self-blame, seeking advice and support. These methods have been classified into two main approaches, problem-solving and emotion-focused approaches to coping, which were widely used to explain coping behaviours within research (Lazarus and Folkman 1984; Chang et al. 2006). Hence, coping has two major roles to play within the concept of stress: regulation of distressing situations through emotions (emotion-focused coping) and taking action to solve a problem causing distress (problem-solving coping). However, Lazarus (1991) emphasised that coping is a very dynamic process where personal and organisational dynamics vary, requiring different coping strategies at different stages of a stressful encounter.

Several studies conducted with different populations in the healthcare setting have reported diverse findings suggesting the use of various ways to cope with occupational stress (Lee 2003; Jenkins and Elliott 2004; Lambert et al. 2004; Chang et al. 2006; Hawkins et al. 2007; Welbourne et al. 2007; Laranjeira 2012). Healy and McKay (2000) undertook a study on 129 registered nurses working in settings from hospitals to nursing homes, using different statistical tools, including the ways of coping questionnaire (WOCQ) and the NSS. This study found that avoidance coping was a predictor of poor mental health in nurses, suggesting that a problem-focused strategy was associated with better

mental health when coping with stress. Payne (2001) also found that both problem-focused and emotion-focused approaches (positive reappraisal) reduced burnout among hospice nurses. This contradicted research findings linking emotion-focused strategy to an increase in burnout (Mark and Smith 2012). Another study by McGrath et al. (2003), exploring stress and coping strategies among nurses reported that nurses used avoidance strategies to reduce the effect of stress. These studies suggested the use of different coping strategies; however, the inconsistencies and mixed evidence in the literature suggest that these strategies could be ineffective. Thus, the effectiveness of coping strategies was seen to differ among people based on individual perception and the availability of resources, such as organisational support (Folkman and Lazarus 1980; Mark and Smith 2012). However, individuals who apply effective coping strategies are able to reduce the impact of occupational stress and increase their job satisfaction. In addition, applying appropriate coping strategies has been linked to a better quality of life, greater mental health and illness remission (Aldwin 2009).

Resilience is recognised as an important factor within a workplace due to the increasing dynamics in organisations (Chatered Institute of Personnel and Development (CIPD) 2011). Hence, the resilience of both individuals and organisations has become paramount in order to survive and thrive in the current working world (CIPD 2011). Resilience has been described as the demonstration of effective coping when an individual is faced with loss or challenging situations and shows the ability to overcome the daily effects of stress (Tugade and Fredrickson 2004). Also, resilience is characterised by the ability to bounce back from a terrible event or absorb high levels of upsetting changes while showing minimal dysfunctional behaviour (Jackson et al. 2007). Resilience is a vital attribute that can act as a psychological and physiological mediator between stress, effective coping and well-being among staff (Tusaie and Dyer 2004). The development of resilience has been viewed as a potential answer to stress associated with the current dynamic workplaces (Foureur et al. 2013). Despite the various terms describing resilience, the main themes were: the ability to persist in overcoming stressful/challenging situations using

different resilient building strategies including optimism, self-efficacy, organisational culture and processes (Adamson et al. 2012; Hart et al. 2014).

The research on resilience has developed in four waves which focused on, firstly, certain individual characteristics, including coping, adaptability and self-efficacy, secondly, the protective mechanisms and, thirdly, interventions directed at changing developmental pathways to promote these factors (Masten 2007; Foureur et al. 2013; Wright et al. 2013; Hart et al. 2014). However, it was also argued that culture needs to be considered when discussing resilience. Thus, the construct of resilience has been conceptualised from an ecological perspective, which formed the fourth wave (Ungar 2008; Ungar 2011). This views resilience as existing within the social and physical setting which is often influenced by interactions between an individual and their environmental factors (McDonald et al. 2016). Hence, this takes account of the processes working across organisational levels and structures within a society to promote resilience (Ungar 2008). Luthar et al. (2000) described resilience as a dynamic process which encompasses positive adaption within the context of substantial difficulty. Despite this description, Luthar et al. (2000) criticised the conceptualisation of resilience by different authors as empirical data was collected within a positivist paradigm rather than qualitative methodologies which takes account of an individual's experience in their own words. Hence, resilience is described as a multi-dimensional and socially constructed concept (Adamson et al. 2012). In addition, resilience was described as when an individual responds more positively to a stressful situation than initially expected (Hunter and Warren 2014).

As noted, the majority of studies on resilience have predominately focused on nursing and other health professionals, rather than midwives or maternity services. Research has identified factors associated with resilience, including active coping techniques, team working, mentoring and support, organisational recognition and reward (Gillespie et al. 2009; Grafton et al. 2010; Seery et al. 2010; McCann et al. 2013). Hunter and Warren (2014) conducted an explorative qualitative descriptive study with 18 midwives, using an online discussion group hosted by the RCM UK communities. This study

identified factors that hindered resilience, including staff shortages and unsupportive organisational culture. These were similar to factors reported within the occupational stress literature, including Kirkcaldy and Martin (2000), Li and Lambert (2008) and Mollart et al. (2013). However, Hunter and Warren (2014) emphasised the proactive use of common coping strategies including self-awareness and peer support, that were key tactics in building resilience among midwives. Other factors that contributed to resilience were a sense of professional belonging and midwives' love for the job. Ablett (2007) noted similar findings on resilience among healthcare workers which supported these conclusions. Although this study was limited, as the midwives had similar years of experience and were self-selected, which reduced the variation in response, it provided a valuable insight into how resilience can be enhanced within the maternity setting. Furthermore, McDonald et al. (2016) interviewed nurses and midwives in a Sydney hospital. This study was undertaken to collect baseline perceptions and experiences of individual resilience in the face of workplace adversity. This study's participants notably thrived in the midst of adversity, which was mainly attributed to collegial network of support and personal traits, including optimism and self-care. This support network enabled successful navigation of organisational hierarchy, reinforced a sense of belonging and lessened personal burden experienced, which influenced positive attitudes to work and increased job satisfaction. Despite the limitation of this study (as it was restricted to a single location which could have limited participation from other nurses and midwives) and variation of experience shared, the findings backed earlier studies which highlighted the importance of support and an organisation's role in developing resilience.

Other studies have identified teaching nurses effective coping mechanisms, including how to practise stress reduction through mindfulness and self-care to promote resilience (Tugade and Fredrickson 2004; Larrabee et al. 2010; Pipe et al. 2012; Foureur et al. 2013; McDonald et al. 2016). Despite this, Ungar (2011) noted the need to explore these mechanisms within a cultural context to understand how individual traits influence resilience.

In addition, research has highlighted that resilience can be used to guide against the development of mental ill-health and emotional exhaustion (Davydov et al. 2010). As noted, highly resilient individuals displayed faster psychological recovery from stress, which also influenced accelerated cardiovascular recovery from negative emotions (Tugade and Fredrickson 2004). For instance, Mealer et al. (2012) conducted a study among 27 nurses working in an Intensive care unit (ICU) in the United States. This study found that optimism, spirituality, social networks, and having a resilient role model were factors used to cope with stress. This revealed that highly resilient nurses reported low levels of anxiety and depression. However, non-resilient nurses lacked such characteristics and emphasised the need to use these factors to build target therapies to promote resilience. This study used semi-structured interviews which enhanced the rich data collected and informed a vital contribution on the effective coping skills used by resilient nurses. Similarly, Zander et al. (2013) conducted a study among five paediatric oncology nurses in Australia to explore their development of resilience and how it aided their ability to cope with work stress. The nurses used different strategies based on the situation at hand, including effective support and self-reflection, which enhanced their ability to develop resilience. Additionally, the nurses noted that good health and energy are requirements to be resilient. Despite the small sample size for this study, it made a notable input to literature that a positive attitude was a significant contributor to resilience.

The majority of the reviewed studies, despite their different methodologies, concluded that to develop resilience, nurses and health workers need to have access to resources that included identifying effective coping strategies and support provided at organisational level (Gillespie et al. 2009; Zander et al. 2013; Hunter and Warren 2014). Thus, McAllister and McKinnon (2009) asserted that learning about and applying strategies of resilience are vital and should be a key component of health and well-being programmes for healthcare professionals. Finally, Judkins (2005) found that resilience in nurses showed a negative association with occupational stress, positive association with job satisfaction and positive correlation with lower levels of burnout experienced. Therefore, understanding how nurses are able to cope

with stressful situations and develop resilience is essential to effectively overcoming such challenges at work (Jackson et al. 2007). The researcher was persuaded that the MWA role should also be taken into consideration.

From the above section, it could be concluded that occupational stress is a global problem within healthcare systems and not limited to one specific region. While there was a wealth of evidence to support the notion of occupational stress within nursing in developed countries, further research is still required within maternity services in developing countries. Similarly, there is a great need to explore the approaches used to cope with stress within maternity settings and strategies used to build resilience (if any).

In summary, the literature described occupational stress as a detrimental, psychological and physiological response to the occurrence of a mismatch between an individual's capabilities and particular job requirements (Bianchi 2004; Alves 2005; Nakakis and Ouzouni 2008). The common sources of occupational stress identified among the healthcare profession include workload, lack of support, staff shortages and lack of resources. The majority of the studies reviewed on occupational stress have been undertaken in developed countries including the USA and the UK and have mainly focused on nurses and midwives. These studies have identified the stressful working conditions prevalent in the healthcare setting and that health workers, including midwives and MWAs, need to cope with challenging working conditions and occupational stress. However, despite this recognition a focus on the MWAs' role seems to have been omitted from key research. Additionally, it was noted that prolonged exposure to occupational stress without effective coping strategies affects both work-life and patient care provided, which in turn leads to a general decrease in well-being (Lee and Wang 2002). The ongoing concern with occupational stress and the impact it has on an individual's health has provided the basis for further and sustained research in this field (Jones et al. 2013).

The exploration of a number of stress theories aided the understanding of the concept of occupational stress and coping within the literature. In addition, this assisted in making the decision to adopt the design used in this study.

Within the Lazarus and Folkman (1984) model of stress and coping, individuals appraise environmental stressors, including levels of potential threat (primary appraisal) and decide on an approach to deal with the stressors (secondary appraisal), initiating coping. Studies have indicated that there are various strategies to cope with occupational stress, including problem solving and positive appraisal (McGrath et al. 2003). However, these strategies have varying levels of effectiveness within the care giving occupations, including maternity care. Although the need to alleviate occupational stress and the use of appropriate coping strategies to improve well-being was emphasised throughout these studies, the need to replicate this with the MWA role seems to have been omitted and not given adequate recognition by researchers.

3.8 Summary remarks on the literature

A substantial amount of the research in the field of occupational stress and coping was dominated by quantitative approaches and the use of singular stress theories to explain research findings (Payne 2001). Most of the studies used different stress scales, including the NSS tool which is an instrument widely used to measure levels of stress (Healy and McKay 2000; Lambert et al. 2004; Chang et al. 2007). These studies used single methods of data collection (questionnaires) within a cross-sectional survey designed to measure occupational stressors. However, in general more than half of the quantitative studies examining the sources and impact of occupational stress among health workers were well designed and used standardised measurement tools. The findings showed how a high level of stress may place health workers at greater risk of developing health issues and reduced psychological well-being. The consistency in findings could, however, be due to the use of the same/similar tools, and particularly the NSS, which was also noted earlier by Wheeler (1998). Although this approach was useful to identify different levels of stress and adds to the body of knowledge on occupational stress, it misses the complexity of the meanings and experiences of occupational stress for an individual. This limitation was also linked to some of the inconsistencies in research findings, which identified the need for a qualitative and/or mixed method approach to researching the concepts of occupational stress. This methodological limitation also partly informed the

decision to use the qualitative methodology and phenomenological approach adopted for this study. This is supported by Lambert and Lambert (2001), who argued that more qualitative research is required in the field of occupational stress in order to fully explore and identify work stressors from a cross-cultural perspective. Hence, it is important to know what needs to be learnt for further understanding before attempting to measure it with statistical tools, specifically when in a different environment.

Another limitation highlighted from a theoretical perspective was that less than half of the studies clearly specified a research question or hypothesis and they lacked a theoretical framework to support the work. The analysis of findings was also complicated in some of the studies by a lack of clear description of how the data was analysed. While a criticism of some of the quantitative studies was the poor response rates and small sample sizes, which potentially limit the generalisation of the research findings to other populations. However, these studies have been able to contribute to the literature on the impact of occupational stress on health workers and on varying levels of stress and have identified common work stressors, including conflict with colleagues (Payne 2001).

Despite notable limitations in other studies researchers were confident of their research findings in areas where the recommendations made could improve the quality of life of healthcare staff, including proper stress management interventions.

Studies conducted using qualitative/mixed methodology and interviews as the method of data collection were very rare. Hence, more qualitative studies exploring the thoughts and experiences of those delivering care and the impact on the health and well-being of health workers in relation to occupational stress and coping are needed. Consequently, the purpose of this study was to explore the concept of stress from the perspective of the MWA using a phenomenological approach (Husserl's 1962).

There were also notable overlaps, as some articles focused on burnout but equally had findings on occupational stress as both constructs were frequently reported concurrently. Although the researchers focused on identifying levels

of burnout among certain healthcare staff, they noted the need to identify underlying stressors if a proper understanding of and measures to reduce high levels of burnout are to be achieved.

Finally, the majority of the research undertaken within the field of occupational stress in the health and social care settings focused on other healthcare workers, specifically on nurses and midwives. Although some research was conducted that included all healthcare staff, this was predominantly undertaken in hospitals in developed countries. This has hindered a like-for-like comparison with the current study population and settings in a developing country. Thus, to gain deeper insight into the MWAs' experiences of stress and coping, more research is required that adopts a more in-depth and explorative, and less structured approach.

CHAPTER 4 RESEARCH STRATEGY AND METHODOLOGY

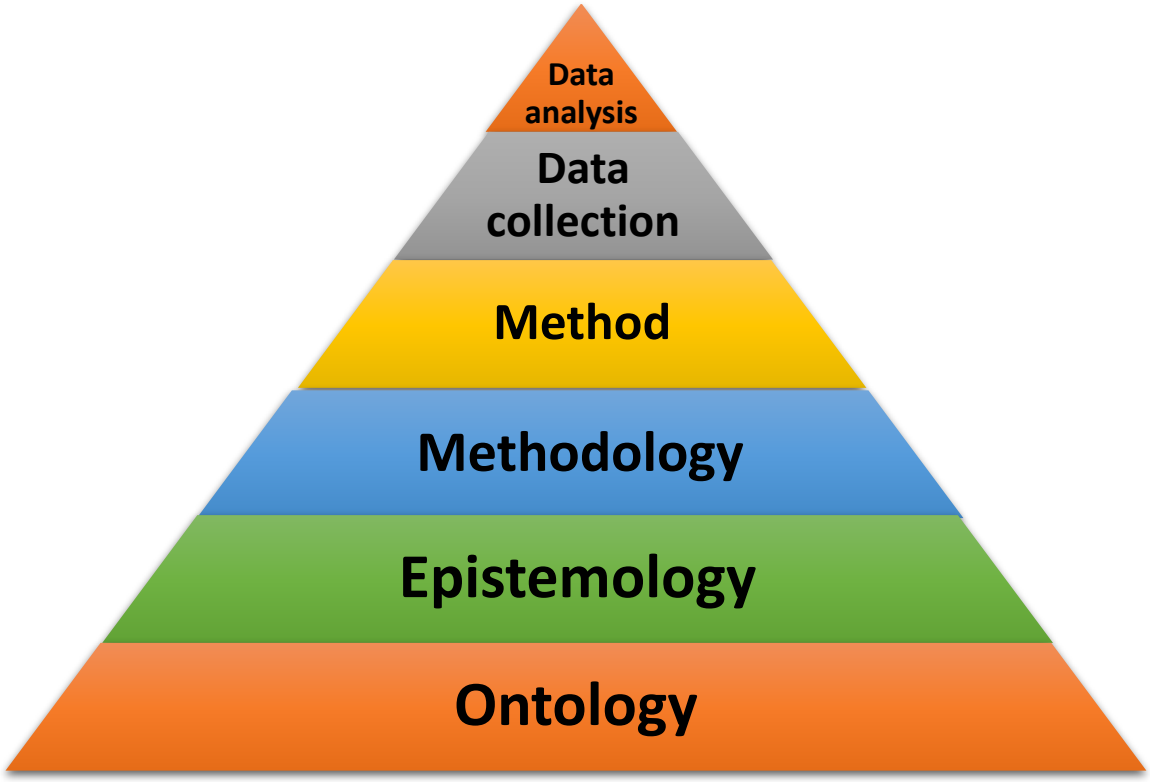
4.0 Introduction

This study aimed to gain an in-depth understanding of the maternity ward attendants' experiences of occupational stress, coping mechanisms adopted and support available within hospital maternity settings in Nigeria. The study explored not only the meaning of stress, but also how the MWAs interpreted and made sense of what they experienced. The meaning of this phenomenon (occupational stress) could not be fully understood from the MWAs' perspective without them sharing or narrating their experiences in their own words and expressions. Thus, to enable the researcher to explore and begin to make sense of their lived experiences, appropriate method of data collection and analysis were required. These formed part of the key processes required to achieve the aim and objectives of this study (Mason 2002).

The aim of this chapter is to explore the philosophical underpinning for this study. In addition, it provides a rationale for the methodological approach adopted and a detailed description of the method of data collection. As the literature review revealed, there is a dearth of research concerning the issue of stress among MWAs. Therefore adopting a quantitative or positivist approach to examine their specific experiences was not considered appropriate for this study. Instead, a qualitative methodology using phenomenological principles was adopted to gain a rich, deep understanding. The rationale for this approach now follows. The origin and definition of phenomenology will be explored, including the difference between Husserl's (1962) and Heidegger's (1977) phenomenological approaches, their relative appropriateness for this study. Furthermore, this chapter outlines the approach to data management and analysis, research sample and size, and ethical considerations for the study. The ethical considerations emphasised the researcher's obligation to ensure the participants were protected from harm (if any) as a consequence of taking part in this study. The chapter is presented in three sections. Section one includes the philosophical

underpinnings and the methodology adopted, Section two details the research method and Section three contains an overview of the fieldwork, ethics and ethical theories, and study validity. Diagram 1 summarises the research process within this study.

Diagram 1: Summary of the research process.



4.1 Ontology and epistemology

Different philosophical approaches to research can be adopted therefore, it was important to have a clear philosophical basis underpinning the research process. The research process is characterised by three key dimensions, namely ontology, epistemology and methodology, which collectively guide the approach taken to research (Creswell 1998; Polit and Beck 2006). It is important that before starting a research project the researcher's epistemological and ontological position is clearly identified, thus guiding methodological decisions (Mason 2002).

According to Mason (2002), ontology is concerned with the nature of reality and what there is to know about the world, while epistemology is associated with how we learn about the social world and what forms the basis of our knowledge. There have been several debates within the literature on ontology and epistemology, which have underpinned the development of social research over the years. These debates have been associated with different epistemological and ontological positions of reality and whether or not it exists, either dependent on or independent of our belief and understanding (Patton 2002; Ritchie et al. 2014). The outcome of these debates has led to the emergence of different philosophical paradigms or beliefs, as described within the literature and associated with methodological preferences, including interpretivism, positivism and realism (Denzin and Lincoln 1994; Saunders et al. 2009). An extensive search of the literature helped shape the researcher's own epistemological and ontological approach, aimed at ensuring consistency between the research stages and deciding on the research methodology, method of data collection and analysis most appropriate for the study. An overview of these paradigms and a detailed description of the approach adopted is provided below.

4.2 Philosophical underpinning

In the early 19th Century, health research, was dominated by positivism (Burns and Grove 2001). Positivism recognises two forms of knowledge: empirical and logical. The former is represented by the natural sciences and the latter by logic and mathematics, with great importance being attached to empirical knowledge (Hughes and Sharrock 1997). Positivism contends that human behaviour is objective, observable and quantifiable. Comte (1850) coined the term 'positivism' and contended that the emerging social sciences must proceed in the same way as natural sciences, using the same rigorous research methods of observation and experiment (Comte and Lenzer 1998). Comte's positivist philosophy incorporates both natural philosophy and philosophy of science. One of the characteristics of this approach to research is the quest for objectivity and distance between the researcher and those being studied (Williams and May 1996).

The positivist approach was developed from a theoretical perspective and a hypothesis is often established before the research begins (Myer 2009). This type of research seeks causal relationships and focuses on predictions and control (Williams and May 1996). While such an approach has been used to study different links between research variables, it has been disputed from a qualitative perspective due to its inability to capture an in-depth understanding of an experience or phenomenon being researched. In addition, this approach treats perceptions of the social world as objective or absolute (Burns and Grove 2001). The positivist stance was criticised by qualitative researchers for its emphasis on social reality as being 'out there' and separate from the individual or individuals being studied (Morse and Field 1996).

Kant (1781) argued that there are different ways of knowing about the world other than direct observation and that perceptions relate not only to the senses, but to human interpretations of what the senses tell us (Ritchie et al. 2014). Over the years there has been a shift from the positivist to a more interpretivist approach within the health research community (Bowling 2014). This is due to several issues associated with health research where links between variables have been studied, but an in-depth understanding of the rationale behind the existence of such variables was lacking. Kant's original work can be seen to be influential as criticisms of positivism led social researchers to claim a 'paradigm shift' and a whole worldview was linked to the growth in the use of interpretivism (Lincoln and Guba 1990).

Interpretivism has its roots in philosophy and the human sciences (Delanty and Strydom 2003). The methodology within this approach centres on how human beings make sense of their subjective reality and attach meaning to it (Hollis 1994). Wilhelm Dilthey, a key contributor to the development of interpretivism, emphasised the importance of 'understanding' and studying peoples' lived experiences within a social context (Blaikie 2009; Ritchie et al. 2014). He argues that self-determination and human creativity play an important role in guiding human action. Therefore, in-order to reveal the connections between various aspects of peoples' lives and the context in

which particular actions take place, it is suggested that research should explore the 'lived experiences' of people participating in the study (Myer 2009).

Other paradigms include constructivism, which can take many forms but has its origin in earlier philosophical arguments based on a rational foundation for knowledge (Schwandt 1998). Constructivism shares an overarching framework with interpretivism, which believes that in order to understand the world one must interpret it (Denzin and Lincoln 2005). Although constructivism shares this general framework for human enquiry, it can differ in its approach. However, while Schwandt (1998) was able to make a distinction between both paradigms, Delanty and Strydom (2003) identified that constructivism has certain limits. Some researchers avoid exploring the perceived differences between interpretivism and constructivism choosing to avoid a potential philosophical debate. The interpretivist approach is now widely used within qualitative research and argues for the uniqueness of human inquiry and notions of choice and, individualism (Denzin and Lincoln 2005).

This argument fits well with the aim of this research study, which explores, maternity ward attendants' (MWAs') perceptions of occupational (work related) stress, possible cause(s), the impact and support available and the coping methods they adopted. The concepts of caring, stress and coping have been explored in different populations within health and social care settings. The vast majority of the literature reviewed used a positivist (quantitative) approach (Healy and McKay 2000; Nabirye et al. 2011). The limitation of this quantitative approach is a lack of an in-depth exploration of respondent's experiences. However, by adopting interpretivism, different interpretations and the effects of caring or working within a maternity setting could be explored. Arguably, an in-depth understanding of the concept of stress and coping cannot be achieved without capturing the subjective reality as experienced by an individual. This fits with the argument that stress and coping can mean different things to different people (Aldwin 2009). Therefore, to fully understand the phenomenon, the different realities of individual MWAs need to be explored. In order to achieve this, an approach aimed at understanding and interpreting social structures and meanings given by individuals to a

phenomenon was adopted, rather than an approach intended to explain reality in terms of generalised facts. To this end, this research was underpinned by interpretivism, with the goal of understanding the meaning of a social situation from the perspective of those who live in it.

Interpretivism is linked to Max Weber's *Verstehen* (understanding) approach, which proposes that to gain an understanding of the people there is a need to try to access their experiences (Ritchie et al. 2014). This is achieved by observing and listening to them rather than applying numerically measured probability as a means of explaining human actions (Myer 2009).

Myer (2009) also argued that the premise of interpretive researchers is that access to reality is achieved only through social constructions such as consciousness and shared meanings. Therefore, interpretivism takes a constructionist position, recognising that people act consciously in order to create and recreate their world, whereas human scientists are concerned with grasping the meaning of the individual's experience (Williams and May 1996). Hence, individuals use language and symbols to construct meaning through which an understanding of subjective interpretations can be achieved (Williams and May 1996).

Burr (2003) argued that language and the use of it not only assists in describing our world, but also helps in how we construct the world we perceive. Burr (2003: 46) went further by describing language 'as a bag of labels used to describe our internal state such as thoughts and feelings'. Therefore, the way language is structured determines the way our experience and consciousness are structured. Burr (2003) cited the example of the phrase 'caring', stating that this means different things to different people based on the language used to describe it. This argument helps to explain the way people think about themselves and represent their experiences to themselves, acknowledging that it could be dependent on the prevailing culture and use of language at that time.

Burr (2003) made a case for the use of language in constructing our experiences; however Potter (1996) warned of the reality that exists beyond language, suggesting that once an individual begins to talk about an

experience it immediately enters the discursive realm. Collier (1998 cited in Parker 1998) highlighted the importance of recognising the interpretive origin of social constructions, where emphasis is placed on the construction of knowledge by individual interactions. Consequently, during individual interviews it would be important to avoid entering a discursive realm and potentially re-interpreting the participants' reality. Parker (1998), therefore argued that to avoid the confusion regarding reality within a discourse it is essential to focus on how individuals construct their accounts.

The philosophical base of interpretivism has also been attributed to hermeneutics and linked with the work of Heidegger and Gadamer (1991) whose ontological emphasis is placed on 'being in the world' (Annelis 1996: 708). Although interpretivism is associated with hermeneutics, Husserl (1928) distinguished between 'fact and essence' and his phenomenological approach encompassed the notion of pure consciousness (Annelis 1996; Speziale and Carpenter 2011). To this end, he sought to establish a science of phenomena as a science of the cognition of essences rather than a matter of facts.

The interpretivist paradigm proposes that all reality is socially constructed, therefore people form their own mental construction of reality (Robson 2002; Denzin and Lincoln 2005)**.** Thus, interpretive researchers adopt an intersubjective epistemology and the ontological belief that reality is socially constructed. This emphasises that reality is socially constructed and the importance of understanding the meaning of social actions and a realisation that appropriate methods of inquiry are required to study the social world because this is mediated through meanings and individual perceptions (Ritchie et al. 2014). Guba and Lincoln (1994) regarded the constructionist paradigm and the interpretive paradigm as interchangeable. However, Denzin and Lincoln (1994) used the term constructive–interpretive to refer to this philosophical paradigm which places an emphasis on qualitative methodologies.

In light of this, the interpretivist approach lends itself very well to the use of phenomenology as it seeks to explore the meanings that are or might be attributed to a phenomenon under observation.

While the interpetivist position is a suitable foundation for the method to be used in this study, consideration was also given to the feminist perspective. Feminism shares some of the characteristics of the philosophical positions discussed above, including focusing on revealing and understanding individuals' (in this case women's) experiences through subjective knowledge (Letherby 2003). Thus, the general consensus of feminist scholars is that feminist research should not just be 'on women' but 'for women' and where possible 'with women' (Ramazanoğlu and Holland 2002). Feminist researchers often "start with the political commitment to produce useful knowledge that will make a difference to women's lives through social and individual change" (Letherby 2003: 4). Furthermore, they are concerned with challenging the absence in research of women's problems and the approach taken to conduct these studies. Therefore, feminist researchers have tended to conduct research in a particular way using unstructured questionnaires and with the researcher embedded within the research process (Reinharz and Davidman 1992). Reinharz and Davidman (1992) contend that the feminist approach to research is influenced by the premise that the nature of reality in Western society is unequal and hierarchical, and thus feminist research is grounded in political as well as academic concerns. Emphasis has also been placed by feminist researchers on the need for reflexivity, namely being reflexive about how data is interpreted and an awareness of the possible introduction of pre-conceived ideas and assumptions into the analysis (Ramazanoğlu and Holland 2002). However, while researchers are encouraged to reflect on and locate themselves in social structures they are reminded that the validity of the findings is dependent on their ability to demonstrate how data is gathered and conclusions reached (Mauthner and Doucet 2003). Strauss and Corbin (1998) argued that researchers may fail to see what is in the data because they arrive at analysis filled with inherent assumptions, and these may be influenced by personal experiences and by being immersed in the literature.

The researcher recognises the stand-point and influence of feminism, and has embraced its principles outlined above within this present study during data collection and analysis.

Letherby (2003) suggested that gender is only one source of power and for many women from different cultural systems gender oppression has not been their primary concern because not all identify with gender alone. In part this is due to women's differences and the power some women have over others, variation in female oppression, both in nature and degree, and being more concerned with other identities, including feminine qualities and commitment to care (Letherby 2003). However, feminism aims to bring the voices that are often left out of key research to the surface and to be heard (Hesse-Biber 2012). This is central to the aim of the present study, which is to explore the perceptions of occupational stress and coping among MWAs and give them a voice within the body of research.

Thus, recognising the feminist perspective also included paying attention to the relationship between the researcher and the respondent (MWAs). Although there have been debates on the power that may exist between the researcher and the participant, feminists have maintained an optimistic view, arguing that this can be minimised by creating a non-hierarchical and friendly atmosphere (Oakley 1981). Naples (2003) added that feminist researchers believe in an inclusive partnership that ensures participants voices are heard, respected and valued throughout the research. Despite this positive standpoint, the potential power relationships between the researcher and the researched cannot be ignored because of our attempts to know and represent or illuminate women's' experiences. It is also recognised that there might be power relations between women based on existing social structures (Cook and Fonow 1991; Hesse-Biber 2012). This implies the need to recognise the potential influence of these

issues throughout the research process including ensuring the questions asked and the research focus (on exploring women's perception and experiences) are equally as important as the data to be generated (Griffin and Phoenix 1994). The approach was used to deal with power relationship in the present study and is detailed in 4.8.3.

Hence, by including a feminist perspective, the researcher was committed to identifying useful knowledge to, where possible, highlight the issues of subordination and social inequality, thus paving the way for change that has the potential to enhance the lives of women. This perspective and the need for reflexivity throughout the research process, a key feature within feminism, informed the methodological decisions within the present study. The overall intention was to enhance researcher's ability to stay close to the participant's perception and voice (Doucet and Mauthner 2006).

In conclusion, it was necessary to adopt an approach that provides the rigour required to achieve the aim and objectives of the study, that include an understanding of the meanings respondents ascribe to a social phenomenon (occupational stress and coping) and which does not exist independently of their knowledge of it. Consequently, interpretivists argue that, meanings are not static but are constantly being created. Thus, basing this study on this philosophy led to the adoption of method of data collection and analysis that allowed meanings of a phenomenon (occupational stress and coping) from the individual perspectives of MWAs to be captured. In addition, this philosophical approach enables the use of different criteria, including those subscribed to by feminist researchers in judging the results of a study (section 4.10). Hence, a qualitative methodology was adopted using a phenomenological approach.

Although the nature of the study and the research questions directed the researcher towards using a qualitative methodology and lent itself to phenomenology, it was essential to explore several approaches within this methodology. Qualitative methodologies include a myriad of approaches/methods focusing on different aspects of research. These qualitative approaches will briefly be explored and a justification for the adopted approach will be provided below.

4.3 Qualitative methodology

This study adopted a qualitative methodology with the rationale linked to the aim of the study and the philosophical discussion presented above. Qualitative

methodologies involve interpretive approaches to the subject matter in an attempt to make sense of, or interpret, a phenomenon in terms of the meanings people attach to it (Creswell 2003). Feminist approaches are believed to be closely associated with qualitative methodologies because it is considered that knowledge is context based (Kralik and Loon, 2008 cited in Watson et al. 2008). Feminism methodologies are respectful of respondents and acknowledge the subjective involvement of the researcher (Letherby 2003). Primarily the aim of qualitative methodologies is to understand a phenomenon within its context or an individual's view of a research subject with the emphasis being placed on understanding an individual's lived experience (Miles and Huberman 1994; Patton 2002). In addition, qualitative methodologies are focused on exploring a phenomenon by taking the perspectives of the research participants as a starting point (Flick 2009). This allows the emergence of interpretive as well as feminist knowledge by unravelling the diversity of individual lives and personal experience (Kralik and Loon, 2008 cited in Watson et al. 2008).

There are several approaches to qualitative studies, including ethnography, grounded theory, case studies and phenomenology (Saunders et al. 2009). These approaches share an overarching aim, which is to have a proper understanding of different aspects of human experience but they differ in their approach and focus (see Appendix 5). However, to ensure this study achieved its aim and objectives, only those methods that would facilitate this were adopted.

Thus, even though the research tended towards a particular approach (Husserl's (1962) phenomenological approach), others were considered to ensure an informed choice of method was made.

For instance, a case study approach focuses mainly on the particular details and complexities of individual cases, which involves studying peculiarities and commonalities of a specific case or cases (Yin 2014). Although this approach has its advantages in evaluating interactions, this does not fit with the aim of an exploratory study describing the essence of a lived phenomenon. Other approaches were also explored but rejected, including ethnography, which is

focused on cultural description. Although this had the potential to generate rich data, describing shared patterns of culture was not the focus of this study. Furthermore, this approach involves the researcher immersing him or herself in the research environment, primarily using participant observation as a research method (Creswell 2013). The feasibility of a meaningful immersion was challenging from an ethical point of view, considering the sensitive nature of the research environment and the need for ensuring a new mother's privacy and dignity. The presence of a researcher could also have had a distorting effect on the data collected (Abbott and Sapsford 1998). Therefore, the phenomenological approach (detailed below) was chosen, as it focuses on describing and interpreting human experience in a credible and insightful way (Moustakas 1994; Burns and Grove 2001; Gerrish and Lacey 2010). Furthermore, phenomenology acknowledges the individuality of research participants, providing an exhaustive description of the essence of the phenomenon being studied (Crotty 1996). Therefore, unlike other approaches that examine cultural interactions or theoretical developments, phenomenology is concerned with understanding the lived experiences of individuals in relation to a phenomenon. This approach suits the aim of this study as it had the potential to yield an in-depth exploration of the phenomenon under observation.

The subject of phenomenology is vast, with different approaches. Thus, to ensure a proper understanding was achieved before commencing the study, the researcher examined the different phenomenological approaches. To this end, the researcher was able to relate the study aim and objectives more closely to the elements of Husserl's (1962) transcendental approach. The next section provides a detailed account of phenomenology and the different approaches, with a focus on Husserl's (1962) contribution to social science, the development of transcendental phenomenology and its application to this study.

4.4 An overview: the definition and philosophy of phenomenology

Phenomenology was first described as a philosophy in Germany before World War I and has since occupied a prominent position in modern philosophy. The

word ‘phenomenology’ incorporates ‘phenomenon’ which comes from the Greek word *phaenesthai,* to flare up or show itself or appear (Moustakas 1994). Phenomenology focuses on an individual’s life experiences with an emphasis on interpretivism, which presented an alternative to the positivist approaches to research (Dowling 2007). The interpretations of human experiences create knowledge, which depend on one’s understanding of the human existence. According to Burns and Grove (2001), there is no single reality or truth and each person has their own unique subjective reality and experience.

Phenomenology is described as a valuable approach, which allows a deeper understanding of poorly understood areas, particularly where complex interactions, feelings and practices are involved (Crotty 1996). According to Spiegelberg (1972), phenomenology is used to investigate a subjective phenomenon, and is based on the belief that essential truth about reality is grounded in our everyday experiences. The fundamental principles of phenomenology are based on acceptance of the human experience as a valuable source of knowledge. Its methodological approaches allow the complexity and depth of human experiences to be revealed (Mackey 2005).

Furthermore, phenomenology is described as both a philosophy and a method which flourished under the influence of philosopher, Husserl (Thorne 2000; Dowling 2007). Husserl’s (1962) established a rigorous and unbiased method that facilitated what he perceived to be essential understandings of the human consciousness and experience (Lopez and Willis 2004; Polit and Beck 2006). However, some authors have concluded that phenomenology is rooted not only in the philosophical traditions developed by Husserl, but also those of Heidegger and Kant. Other philosophers have also influenced the development of phenomenology, including Decartes, Bretano, Shutz and Dilthey. The extent of these contributions has been discussed by several authors, including Moustakas (1994), Holloway and Wheeler (2002) and Speziale and Carpenter (2011).

There are three dimensions to the development of phenomenology: the transcendental (descriptive) phenomenology of Edmurnd Husserl (1859-1938), the hermeneutic (interpretive) phenomenology of Martin Heidegger

(1889-1976) and the existentialist phenomenology of Merleau-Ponty (1908-1961) and Jean–Paul Sartre (1905-1980) (Holloway and Wheeler 2002). These dimensions depict the three historical phases of phenomenology: the preparatory, German and French phase (Speziale and Carpenter 2011).

4.4.1 The historical phases of phenomenology

There are different versions of the development of phenomenology. The extensive literature on the subject shows how the misconception and misinterpretations of how phenomenology came to be, both as a philosophy and a method of enquiry.

Qualitative approaches including phenomenology challenged the dominant positivist approach to research, which perceived knowledge to be scientific and authentic, with facts contributing to scientific law (Smith 2008; Ritchie et al. 2014).

Husserl is regarded as the core figure in the development of phenomenology and was influenced by Franz Brentano (1838-1917). Brentano's doctrine of intentionality influenced the work of Husserl (Spiegelberg 1972; Speziale and Carpenter 2011). Brentano's focus on the separation of psychological from non-psychological or physical phenomena led to his doctrine of intentionality which he described as the decisive constituent of psychological phenomena (Spiegelberg 1972).

However, prior to these developments, the philosopher, Immanuel Kant (1724-1804), held the notion that interpretation and imagination were important factors in the organisation of perceptions in the social sciences (Smith 2008) . Kant believed that perceptions exist and are made sense of within a mental framework. Furthermore, he argued that the mind is a creative agent in the production of knowledge and cannot be understood if methods of natural science are imposed. This explains why Kant emphasised the use of perception and conception in research (Smith 2008; Ritchie et al. 2014).

Both Husserl (1962) and Brentano (1874) share the view that any worthwhile philosophy or method must be rigorous. This nurtured their mutual ambitions to create a precise approach to research rather than one that speculatively

generates arbitrary opinions and views (Moran 2000). The subsequent phase of Husserl's academic career was mostly referred to as his 'descriptive phase', during which he became more confident in his philosophical underpinnings and introduced different methodological approaches, including epoché (see 4.4.2).

In essence, Brentano and Husserl's work set the scene for the major advancement of phenomenology, which was regarded as the first (preparatory) phase. Both philosophers agreed that the human mind is not limited by external reality.

The second phase of the phenomenological movement was called the German (second) phase. Husserl was also primarily involved in the German phase and was later joined by his student, Martin Heidegger (Holloway and Wheeler 2002). Husserl's contribution to this phase was centred on his search for rigour, his criticism of positivism and his development of three main concepts which include phenomenological intentionality, essence and phenomenological reduction. Within this phase, two important elements were developed; the notion of intersubjectivity and the idea of lifeworld, which is about the lived experiences of individuals. Schwandt (1998) added that the way of making sense of any experience is essentially intersubjective in nature. Heidegger's contribution to this phase was centred on the notion of '*Dasein'*, the nature of being and existence (Robson 2002; Mackey 2005). While Husserl considered the ways in which we understand things about the world (epistemological approach), Heidegger (1977) examined our nature of being in the world (ontological approach). Consequently, this division in their work became a contentious issue, not only in their personal relationship but also within the academic world (Speziale and Carpenter 2011).

Heidegger questioned the feasibility of 'bracketing off preconceptions' about a particular experience. Although he acknowledged the benefits of bracketing assumptions or preconceptions, he argued that there was a limit to the extent to which a researcher can achieve this (Speziale and Carpenter 2011). To this end he developed the hermeneutic method of enquiry that went beyond Husserl's descriptions of experiences into interpretation. This claimed that

description is a mere derivative form of interpretation, a position heavily disputed by followers of transcendental phenomenology (Moran 2000). Heidegger believed that all interpretations have presuppositions and meanings embedded within them (Reiners 2012). Heidegger's idea influenced other philosophers, such as Merleau-Ponty (1908-1961) and Jean –Paul Sartre (1905-1980) and, led to the development of the third (French) phase of the phenomenological movement.

The French phase mainly occurred under the influence of Gabriel Marcel (1889-1961), Merleau-Ponty (1908-1961) and Jean–Paul Sartre (1905-1980) (Holloway and Wheeler 2002). The central idea within this phase was the idea of existence and essence. Merleau-Ponty's focus was on perception and the creation of a science of 'being'. However, the main concepts developed during this phase were embodiment and being-in-the world (Speziale and Carpenter 2011). Merleau-Ponty's phenomenology is existential because it deals with the existence of people in a pre-given world. Hence, it is only through consciousness that an individual is aware of being-in-the-world and gains access to this world through the body.

In summary, philosophers have different interpretations of phenomenology with the main differences between Husserl's and Heidegger's phenomenological approaches being;

- Bracketing is a key concept in Husserl's phenomenology but not within Heidegger's phenomenology.
- Husserl's approach focuses on description and obtaining fundamental knowledge of a phenomenon, while Heidegger's approach places emphasis on interpretation, understanding and reality (Moustakas 1994; Robson 2002; Speziale and Carpenter 2011; Reiners 2012).

However, despite the constant and intense academic debate about the various approaches, the researcher remained enthusiastic about and interested in the choice of phenomenology for this study. Most specifically, the work of Husserl (1962) and transcendental phenomenology, his genuine and rigorous approach to understanding a phenomenon, describing the person's subjective experiences without the influence of preconceptions. The researcher,

however, came to the conclusion that to mix the different approaches of phenomenology would not only lead to confusion of methodological design, but also create challenges for the data analysis. Hence, the choice of transcendental phenomenology follows on from this broad exploration used to clarify the researcher's understanding of the assumption of phenomenology. The next section will explore the adopted phenomenological approach (transcendental phenomenology) and the key elements.

4.4.2 Edmund Husserl's (1962) transcendental phenomenology

The researcher set out to understand the work of Husserl, the evolution of his ideas and the development of a new philosophical mode of enquiry. While exploring Husserl's work it was apparent how his philosophy developed, being intertwined with his personality and status as a German academic. This approach to understanding made it easier to connect with some key developments in Husserl's work and in the evolution of phenomenology as a recognised mode of enquiry.

Husserl (1962) initially claimed that phenomenology was a form of positivism based on the idea that positivism is a philosophy founded on a system of knowledge that is free from ideal presuppositions (Sinha 1963). However, as Husserl progressed in his philosophical journey he observed that the positivists were prejudiced in not accepting anything other than particular types of data (Sinha 1963). In addition, Husserl was concerned that an attempt to interpret an individual's or participant's contribution using fore-structure and/or foreknowledge as the basis of interpretation can lead to the misunderstanding of the essence of an experience (Dowling 2007). Husserl (1962) considered human experience as the fundamental source of knowledge and meaning (Racher and Robinson 2003). Husserl (1962) rejected the extreme empiricist (positivist) position and sought to forge a path that would confirm human consciousness as it relates to the real world (Racher and Robinson 2003). However, while the contradictory aspect of Husserl's (1962) view of positivism is noted, the positivist position in Husserl's approach is acknowledged in his overarching thought that 'to know is to see' (McConnell-Henry et al. 2009). Thus, with Husserl's position and its contrast with positivism

clearly outlined he moved towards an approach called transcendental (descriptive) phenomenology. From this perspective Husserl (1962) focused on returning to things themselves, the essence of consciousness and perceptions of the human world, the very nature of a phenomenon that makes it what it is.

Transcendental phenomenology is to clarify the intentional sense of claims as well as other entities of meaning. Consequently, Husserl (1982) proposed the method of phenomenological reduction, one of the key process that facilitate derivation of knowledge. Another key component of transcendental phenomenology is epoché. This implies putting aside what is previously known about a phenomenon (bracketing) and seeing what is presented without preconceived ideas (Moustakas 1994; Newell and Burnard 2006; Creswell 2013). Bracketing ideas or pre-assumptions will not only allow the findings to reflect the subject's own opinions but will also limit, if not eliminate, any chances of bias which can be difficult to control by a researcher. Nevertheless to achieve bracketing, Wall et al. (2004) advised that a researcher needs to engage in reflexivity.

Reflexivity involves the realisation that researchers are part of the social world that they study (Frank 1997). This realisation was the result of honest scrutiny of personal values and beliefs that may impinge on the research process (Porter 1993). To enhance the researcher's ability to bracket, it was suggested that a researcher should use a reflexive diary during the research (Wall et al. 2004). This was supported by Polit and Beck (2006), who stated that descriptive phenomenological research includes bracketing as well as writing a reflective journal throughout the research process. Therefore, to ensure reflexivity is brought into consciousness, the researcher used a reflexive diary to collect thoughts and issues during the research process, including data analysis. Therefore maintaining a reflexive diary was also supported by Ahern's (1999) 10 tips for reflective bracketing and was used to guide the identification and elimination of bias during the research.

Other key components of transcedental phenomenology are intuition and imaginative variation (Moustakas 1994; Polit and Beck 2006). Moran (2000)

described intuition as an eidetic comprehension or accurate interpretation of what is meant in the description of the phenomenon investigated. According to Moustakas (1994), intuition is the starting point for deriving knowledge of human experience. This involves attempting to examine the phenomenon as freely and unprejudiced as possible to allow precise description and understanding (Dowling 2007). This leads to imaginative variation which allows one to grasp the structural essences of experience (Moustakas 1994). Langdridge (2007) described this as a process of looking at a phenomenon from different perspectives and imaginatively varying the features.

4.4.3 Strengths and limitation of phenomenology

Phenomenology provides a rigorous approach to answering important questions of how a phenomenon is perceived, and allows the complexity and depth of an individual's experience to be revealed (Moustakas 1994; Mackey 2005; Polit and Beck 2006; Speziale and Carpenter 2011). Findings from a phenomenological study emerge from the data analysis rather than being imposed by a researcher. Within phenomenology is the key principle of bracketing, which plays an important role in allowing a researcher to present meaning units, which are true reflections of a participant's view as detailed in an interview transcript (Gearing 2004). This minimises the researcher's influence on research findings.

Phenomenology, just like every other research method has its limitations. However, the researcher believes the strengths of phenomenology outweigh its limitations.

4.4.4 Rationale for adopting transcendental phenomenology in this study.

Occupational stress has been defined based on the different models detailed in Chapter 3. However, despite the emphasis placed on the subjective nature of stress as defined in Lazarus and Folkman's (1984) theory, this has limited recognition within the relevant literature. Although, quantitative approaches have contributed to the body of research through different stress measurement scales, the meanings attached to an individual's experience of stress were limited in the literature. Hence, the use of phenomenology in this study was a

significant step in contributing qualitative data to increase the body of knowledge on occupational stress. This was intended to explore the social construct of the phenomenon and highlight the significant meanings an individual attached to the experience of stress and coping. The subjective nature of the experience of occupational stress has been further elucidated, specifically among MWAs in maternity settings in Nigeria.

In summary, within phenomenology, subjective knowledge and internally constructed reality are socially constructed by research participants. There are differences between Heidegger's and Husserl's versions of phenomenology, the former being interpretive and the latter descriptive. Phenomenology is asserted to facilitate the empowerment of participants as they take part in the research studies because it allows a form of equality within the dialogue. The transcendental phenomenology chosen for this study was designed to gain a deeper understanding of the MWAs' perceptions of stress and coping mechanisms adopted within a hospital maternity setting. The utilisation of an in-depth approach allows the true meanings of phenomena to emerge, solely reflecting the accounts of the research subjects (MWAs) without being influenced by the researcher's assumptions or ideas (bracketing). Therefore, the decision to use Husserl's phenomenological approach was a complex one, grounded in an understanding that the selected approach was the best method for answering the research questions and meeting the objectives of the study. This included collecting rich, in-depth descriptive/narrative accounts of the MWAs' perceptions of the phenomenon under study through the use of semi-structured interview.

4.5 Researcher's role

A researcher's role within a qualitative (phenomenology) study is not confined only to the interactions with participants during an interview, but it also involves being immersed in the data (Creswell 2003). Hence, the role of a researcher can influence the entire research process, including choice of research questions, research design, ethical approach and data analysis (Creswell 2003). Therefore, it was important to ensure that the role of the researcher was clearly defined. While considering the philosophical underpinning

discussed above, consideration was given to the guiding feminist principle in equalising or reducing power imbalances in the researcher-respondent relationship (Ramazanoğlu and Holland 2002). Hence, ensuring that participants' voices are heard, valued and respected by the researcher throughout the research process (Ackerly and True 2010). A commitment to the use of reflexivity also promoted transparency. This reiterates the feminist principle whereby a researcher is aware of the way their position affects the research process (Watson et al. 2008). The process adopted to achieve reflexivity is detailed in Section 4.4.2 above.

Furthermore, Moustakas (1994) proposed that when a researcher's role is adequately identified and the core principle of phenomenology is achieved (bracketing) through reflexivity, the entire research process is refocused on the study questions which ultimately reduces interviewer bias.

4.6 Sampling approach adopted

The choice of a sampling technique and strategy needs to be closely aligned to the research purpose (Patton 2002). Various sampling techniques are used within qualitative research, including purposive, convenience and theoretical sampling (Holloway and Wheeler 2002). Convenience sampling is an approach based solely on who is available to participate in a research study (Patton 2002). However, this approach has been criticised as it can be perceived as having low credibility and being more likely to yield poor information (Patton 2002). Theoretical sampling is mostly associated with grounded theory where a researcher samples incidents or units on the basis of their potential manifestation of theoretical constructs (Strauss and Corbin 1998). Purposive sampling involves selecting a sample based on particular features or characteristics which enables detailed exploration and understanding of the phenomenon being studied (Mason 2002; Polit and Beck 2006). This approach is known to yield data required to meet the specific needs of a study (Robson 2002). Thus, a sample was sought that would provide rich information about the meanings of and insights into the phenomenon studied, and not for statistical generalisation (Onwuegbuzie and Leech 2007; Denzin and Lincoln 2011).

Therefore, consistent with phenomenology, a purposive sampling technique was adopted for this study although an element of convenience sampling was adopted in that the geographical location of the hospitals needed to be accessible to the research. Purposive sampling was applied to this study to enable the necessary and in-depth information related to the perception of occupational stress and coping to be collected from MWAs that shared the same work experiences and settings. In addition, this approach best suited the research aim, which was an in-depth exploration of the phenomenon being studied in order to produce a rich description. To meet the criteria of purposive sampling, the research participants had to have experience of working on a maternity ward within a hospital setting and were willing to share this experience voluntarily.

4.6.1 Study sample

The study sample was from a population of MWAs working in hospital settings in Nigeria. An overview of the selection and inclusion criteria used will be discussed below. Participants were selected from government hospitals located in the South-Western region of Nigeria that had high birth rates and consequently employed a large number of MWAs. This was to ensure there was an adequate cluster of MWAs from which participants could volunteer. However, due to the lack of statistics and employment records on government websites, this information was requested from individual hospitals to determine (if any) the number of MWAs employed within their workforce. The hospitals were identified based on records from the Nigerian Federal Ministry of Health and other international organisations, including the WHO.

The geographical location of hospitals was also considered as part of the selection criteria, as the hospitals needed to be easily accessible by the researcher. This was identified with elements of convenience sampling because transportation in Nigeria is inadequate and poorly developed (Ritchie et al. 2014). The approach used to gain access to the hospitals will be discussed in Section 4.8. The exclusion criteria are listed below, and they include:

- hospitals outside the South-Western region

- ward attendants not working within the maternity settings
- non-governmental hospitals
- MWAs who have been employed for less than six months.

4.6.2 Sample size

Sample sizes in qualitative research are typically small, with an emphasis on the volume and richness of information collected (Patton 2002). The number of participants required to ensure an appropriate sample is something that is debated within the literature as studies have tended to be designed on an individual basis to meet the needs of respective studies (Onwuegbuzie et al. 2010). Researchers have only been able to give limited definitive guidance on a number range of participants to be used within a study.

According to Newell and Burnard (2006), it is rare to use more than 30 participants for an in-depth examination of data, while Morse (1991) stated that most studies within ethnography and grounded theory were based on a sample of 30 to 50 participants. Creswell (2013) added that the ideal figure should be between 20 and 30 for a grounded theory study and 5 and 25 for a phenomenological study. However these figures could be larger (Charmaz 2006). As noted by Onwuegbuzie and Leech (2007), these numbers seem to have been selected in an arbitrary manner. Although these guidelines were helpful, the researchers did not state how they were able to arrive at these figures. However, Patton (2002) provided some justification for these figures, stating that in qualitative research, there are no rules for sample size. Therefore, sample size depends on ‘what you want to know, the purpose of the study, what is at stake, what will be useful, what will have credibility and what can be done within the available time and resources’ (Patton 2002: 244). To this end, there was no set figure for the sample size, but the guidelines of earlier researchers was followed based on the general conception that generating rich and in-depth data is the aim of qualitative research and not focused on sample size (Creswell 2013).

Only MWAs who had worked in their current role for a minimum of six months were invited to participate in the study. This ensured the MWAs recruited were

actively involved on the maternity wards and had the experience the researcher wished to explore.

Hence, the final sample size of this study was based on certain criteria stated above, including data saturation. Evidence of data saturation occurred when a depth of rich and detailed description was achieved and new data collected was not adding material of significant importance to the study (Patton 2002). Adopting this approach ensured that the researcher did not compromise the quality and worthwhileness of the overall study (Mason 2002; Robson 2011). This approach to sampling and sample size aids the flexibility of the research design to accommodate unanticipated changes that could unfold during data collection (Patton 2002). The final sample size and their biographic characteristics are detailed in Chapter 6 (findings chapter).

4.7 Research method

Introduction

This section aims to provide a detailed description of the method of data collection adopted and the justification for it use within this study. Furthermore, this section provides information on the approach to data management, data analysis and the qualitative criteria used to achieve trustworthiness. The sample population and ethical considerations for this study are also detailed within this section. The ethical consideration requires the researcher to ensure the study participants were protected from harm (if any) as a consequence of participating in this study.

This study used semi-structured interviews conducted with the maternity ward attendants. According to Creswell (1998), the benefit of qualitative interviewing is to identify perceptions/opinions, knowledge, feelings and language in relation to the phenomenon being studied. Mason (2002) suggested that the choice of qualitative interviewing can be based on a researcher's ontological position if people's experiences, interpretations, views and interactions are meaningful elements to the social reality a study intends to explore. This choice should also be linked with an epistemological position, whereby the meaningful way to generate data involves talking with people to gain access to their accounts of a phenomenon. This was consistent with the interpretivist

approach adopted within this study. Therefore, the aim of this study was achieved by using appropriate data collection method (semi-structured interviews).

4.7.1 Semi-structured interviews

Semi-structured interviews were used as the primary method of data collection and these were recorded using a digital recorder (with participants' agreement) followed by a verbatim transcription. The interview was conducted in the form of face-to-face verbal interaction. This is one of the most common forms of interviewing in research (Denzin and Lincoln 2008). There are other methods of data collection within qualitative methodology, including observation and documentary analysis (Creswell 2003; Myer 2009). These methods were considered however, interviews were adopted as the method for this study, because interviews are a prominent method of data collection within qualitative methodology and a key technique in phenomenology (Kvale 1996; Langdridge 2007).

Saunders et al. (2007) identified different forms of interview, including semi-structured, structured, unstructured and focus groups. However, for the purpose of this study, semi-structured interviews were the chosen method, due to their flexibility and the opportunity to probe further during the interview sessions, enhancing the validity of responses (Langdridge 2007). In addition, they aid in the effective identification of the essential structure of a phenomenon (Englander 2012).

Dawson (2009) argued that the semi-structured interview is widely used within qualitative research due to its ability to work through from pre-set questions to questions that arise from a participant's response. This was seen as significant for the researcher, not only in collecting rich and in-depth description of the phenomenon for analysis but also because it offered the opportunity to explore areas not previously considered by the researcher. Furthermore, several researchers have supported the use of semi-structured interviews in phenomenology where the depth of meaning is important, with the primary focus of gaining insight and understanding of a phenomenon (Ritchie and Lewis 2003; Munhall 2012).

Semi-structured interviews were chosen as a method despite some of the benefits associated with other forms. For instance, structured interviews use a more controlled means of data collection but are limited to a set of categories, allowing little room for variation to explore a participant's response (Denzin and Lincoln 2008). Although this is seen as an advantage by some researchers in terms of control over the interview process, it clearly has the potential for missing out vital information. This is due to the rigidity in terms of not allowing complexity or ambiguity in a respondent's position to be unravelled (Smith 2008). These limitations, from the researcher's perspective outweighed its advantages and supported the use of the semi-structured interview for its flexibility and structure, allowing any form of ambiguity to be explored or clarified.

4.7.1.1 Interview schedule

The interviews were conducted using a semi-structured interview schedule designed with open ended questions to explore the phenomenon under study. This interview schedule included prompt questions used to elicit more information where required (Appendix 6). Importantly, Robson (2011) emphasised the need to ensure that questions asked are appropriate to meeting the aims and objectives of the study. This was taken into consideration when designing the interview schedule which was structured around the key aims and objectives of the study. The questions were designed to explore the MWAs' perceptions of occupational stress, the causes, impact, support available and coping methods adopted. In addition, a data sheet was used to collect biographic details of the participants to provide a contextual description of the sample (Appendix 7). The interview schedule started with a question that was used to set the scene for the interview and to put the interviewees at ease. This approach was intended to get the MWAs to talk generally about their role and experiences of working within the maternity ward or hospital, in order to reduce any inhibiting effect of interviews and build good rapport and confidence in the process before moving on to more specific questions. At the end of the interview the participants were asked if they had any other information to add or wished to talk about any aspect they felt was important to the study. Finally, requests were taken in advance from MWAs

who wished to read through and provide comments on the transcripts of their interviews.

4.7.2 Field notes

Field notes and memo writing were used to record contributing factors that were not reflected in the interview recordings (Onwuegbuzie et al. 2010). Although the use made of this facility was modest, it helped retrospectively to clarify the meaning of nonverbal features during the interview, such as gestures used to emphasise a spoken word or phrase (Robson 2002; Onwuegbuzie et al. 2010). Memo writing following interviews serve as an aide memoire for the researcher and is considered good practice in qualitative research (Miles and Huberman 1994; Robson 2002).

4.8 Field work: gaining access and data collection

Negotiating and gaining access was a key aspect of this study. As Feldman et al. (2003) conclude, gaining access to an organisation can be difficult and time consuming. Creswell (2013) notes that gaining adequate permissions to a study site is crucial thus enabling the collection of data. A list of potential hospitals was drawn up by the researcher, based on the selection criteria outlined in section 4.6.1.

Ethical procedures were followed throughout the course of gaining access to all three hospitals participating in the research study as follows. At the first hospital following an initial meeting with the Apex nurse, a letter of introduction stating the intention of the study and a response form (Appendices 9 and 10), were submitted for review by the Medical Director as requested. These were considered by the chair of an ethics committee recently created within the hospital. The researcher met with the chair and was able to discuss the study and what it entailed before proceeding to the ethics committee for further review. The researcher returned to the hospital for ethics feedback and was advised that the ethics committee had deferred the decision to allow access to the researcher to the Apex nurse who approved the request. The reason for this was that the research did not involve any medical procedures and no patient contact was required. Hence, the study was signed off at the first level

review. The researcher then received formal approval with an instruction to include the approval reference on all consent forms (Appendix 10).
The second hospital had a similar process to the first hospital but without recourse to an ethics committee; however, the letter of introduction and other documents were submitted to the Medical Director's (MD) office. The researcher was granted a formal approval without any objections or amendments (Appendix 11).

Finally, at the third hospital the research request letter was submitted for consideration and was promptly reviewed by the MD and approved, and instructions were given to the coordinator of the MWAs in the hospital.

4.8.1 Recruitment strategy for Maternity Ward Attendants

A preliminary/introductory meeting was convened at each participating hospital site. This provided the researcher with an opportunity to introduce prospective participants, namely MWAs to the study. Some MWAs who were not at the preliminary meetings were provided with an opportunity to hear about the study when they briefly gathered at their work base (either before or after shift changes). All MWAs who were briefed about the study were provided with a pack of documents including an invitation letter, information sheet and a consent form outlining the purpose and requirements of the study, what participation entailed and the researcher's contact details (Appendix 12, 13 and 14). MWAs appeared to respond positively to the study during these briefing sessions.

4.8.2 Pilot study

According to Bryman and Bell (2011), a pilot study is a smaller version of the main research to test components of the study to ensure they all work together to achieve the set purpose. Importantly, conducting a pilot study is essential as it helps to refine data collection instruments (if required) in order to avoid or minimise problems during administration to participants. This also ensures the questions within the research instruments are clear to participants (Saunders et al. 2007).

Conducting the pilot study served as an opportunity for the researcher to practise interview skills, as well as taking note of the strengths and weakness of approaches used to allow appropriate arrangements to be made. This increased the researcher's competency and provided an opportunity for enhancing interview techniques.

The pilot study comprised of two MWAs who were keen to take part in the interviews. A meeting was scheduled and the MWAs already had a copy of the letter, the information sheet and the consent form from the previous contact. To ensure proper understanding, the researcher explained the information contained in the documents, specifically the information sheet and the consent form. Although the MWAs understood English, during the pilot the researcher had to explain the study using the local language, which the MWAs sometimes used at work. The MWAs confirmed they were satisfied with all the information they had received and signed the consent form. Mutually convenient arrangements were made for the interviews. This took into consideration the MWAs' and researcher's travel time, work commitments and security concerns (see 4.8.4). The researcher noted during the pilot that being able to speak the local language helped to eliminate any degree of intimidation or power influence. The MWAs were able to provide authentic answers, which increased the quality of data collected and enhanced shared understanding. This made it much easier for the MWAs to express themselves or explain certain things and the researcher collected richer information as a result

Following the pilot study, the researcher was prepared to adopt a more flexible approach to the interviews and made use of local language as appropriate. Also, the researcher recognised that using the MWAs usual 'rest place' was a preferred venue for the interviews. The actual interview instrument did not require any adjustment.

4.8.3 Interview sessions and dealing with power in the relationship

A total of 22 interviews with the MWAs were conducted, with each lasting on average 50 to 55 minutes. Consent forms were signed by the MWAs and returned to the researcher on or before the interview day. The interview began

with some complimentary greetings and a brief recap of what participation entailed. This was to create a relaxed atmosphere and enhance participants' confidence in the research. Additionally, the researcher's ability to communicate in the MWAs' language enhanced the rapport during the interviews. This also contributed to the researcher's cultural understanding of some of the MWAs' statements.

Throughout the interviews, the researcher got the impression that the MWAs saw the researcher as someone that was familiar with the culture, who spoke their language and they felt at home with her. Although the researcher was not in a similar position as the MWA in terms of job experience, the ability to speak their language and some familiarity with their work setting and cultural practices helped to settle them. Also, making references to such cultural familiarities within initial conversations, prior or after the interviews, helped to minimise the potential power the researcher could have been perceived to have exercised to influence the study. The MWAs are a very neglected group of healthcare workers and they felt listened to during the interviews, a key role of the researcher. The researcher's awareness of the MWAs' subordinate role in the organisational hierarchy and being able to connect with them also helped to put them at ease. The MWAs readily spoke with the researcher, making them comfortable and giving them power over the research process through voluntary participation and not being coerced. Furthermore, the MWAs had the expert knowledge the researcher relied on to gather the information needed for the present study. This contributed to the power the MWAs had, as the researcher did not have any expert knowledge and endeavoured to capture every detail given during the interview. In this study, the researcher was subordinate, giving the MWAs a voice and handing power over to them. However, it is important to note that while the principles of feminism were adopted in the current study, the researcher was conscious to avoid exploiting the participants and giving a voice to this oppressed and subordinate group of workers. This was mainly because feminism did not fit well within the Nigerian context due to the variation in social structures among women within the work setting. This was evident during the conversations with MWAs. Hence, as some of the MWAs often referred to the researcher being

familiar with such practices, this gave the impression that the research process was not influenced by power imbalance but, rather, benefited from the MWAs full engagement with the study. This reflection indicated a balance was achieved in the relationship between the researcher and the MWAs. The MWAs ability to choose the location and time for the interview gave them a sense of control over the interview process

The interviews had a conversational flow with the interview schedule serving as a guide while biographic data was collected during the course of the session. This was because as the questions were being asked, responses led to different aspects of the interview schedule and also provided some biographic information. However, in some situations where biographic data could not be woven into the interview, this was collected at the end of the interviews. This flexible style of interview is supported by Patton (2002).
The researcher noted that asking for the biographic details before the interview began created more of a formal setting rather than the relaxed environment which the researcher wanted to achieve. This approach was used all through the data collection (interviewing). The interview then progressed with questions about the MWAs' job role and tasks. Subsequent questions focused on their experience of occupational stress, the sources or factors that caused it, their perceptions of how they coped and the support they received within and outside the workplace. After each interview the researcher made completed brief field notes (Robson 2002). Time was allocated to undertake this activity following interviews. These notes were referred to during the data analysis to ensure every detail was carefully captured within the results of the study. Although field notes were taken, this was kept to a minimum to guard against any form of disruption during the interviews themselves, enabling the researcher to engage in the interview.

4.8.4 Interview location and setting

The researcher would ideally have preferred a quiet, designated room within the hospital for the interviews or a mutually agreed location outside the work environment; however the reality of getting a suitable or quiet place was

difficult. Due to the tight schedules the MWAs worked, the interviews could not be conducted outside the hospitals. Fortunately, the interviews were conducted with minimal noise interruptions within the hospital. This also gave the researcher the opportunity to witness and experience the state of the MWAs' base, which also doubled as the store room. However, it was quite a conducive environment for an interview because it was relatively quiet and a preferred location for the MWAs. The MWAs' base is a place where they can be located by the midwives if they are not on the ward or are taking a break (if any). The interviews were scheduled either an hour before or after a shift. Some of the MWAs arrived at work about an hour or more before the start of their shift to avoid the heavy road traffic and suggested it would be a good time for the interview. The MWAs ability to choose the location and time for the interview gave them a sense of control during the interview process.

4.8.5 Data management:

Each consent form was assigned a pseudonym to protect the identities of MWAs and also to ensure confidentiality and anonymity were adhered to throughout the study. The researcher took every measure to protect the privacy of MWAs, securing the transcripts in a locked cabinet to be destroyed once the study was concluded and ensuring no one had access to them.

Following the interviews, each conversation was transcribed verbatim by the researcher to ensure important information was not lost during transcription. This also helped the researcher to recall and contextualise the interview conversation through repeated listening to the interviews during and after transcription. At this point, the researcher incorporated the field notes, including nonverbal expressions collected. Following transcription and repeated listening to the interviews, the researcher became more familiar with the MWAs' perceptions and responses within the interviews. As some of the interviews were in the local dialect of Yoruba, the researcher translated the interviews into English during transcription. After each transcription the researcher listened to the original interviews again to ensure the translation was accurate. The researcher's ability to translate the interviews meant that the original meanings were closely preserved and authenticity was ensured in

the translations (Welch and Piekkari 2006). Additionally, to double-check the translation for further accuracy and to ensure no meaning was lost, the researcher invited a colleague who understood and was proficient in the language to listen and check the transcription. Each transcription was assigned a pseudonym corresponding to that earlier assigned to the MWA and the consent form. The researcher stored the original interviews separately, away from the transcriptions, to enforce ethical principles, including maintaining confidentiality and anonymity principles.

Utilising field notes

The field notes served as a useful tool during the interviews to collect non-verbal communications, which provided an important context for understanding the emotional or situational setting when interpreting MWAs' responses. This helped the researcher to interpret what the MWA said more openly and accurately, as reflected in the data analysis. All non-verbal communications were incorporated into the transcription as detailed within interview quotes. Additionally, the researcher was able to record physical reactions to support verbal descriptions, for instance of the storage room where most of the interviews were conducted. This gave context to the discussions detailed in Chapter six.

In summary, the field notes enhanced the research process, the richness of data collected and helped the researcher to stay true to the information while analysing the MWAs interviews.

4.9 Data Analysis: Justification for using thematic analysis

The data collected within this study, consistent with its methodology, was descriptive data (qualitative textual data) which solely reflected the account of the MWAs. This was a source of well-grounded and rich description of occupational stress and coping from the MWAs' perspective. Statistical analysis was limited to the biographical descriptive statistics used to describe the MWAs. The descriptive statistics were analysed with computer software called Microsoft Excel which allows a researcher to perform basic calculations

and use graphing tools to represent data. These graphs are presented in Chapter five (findings).

Despite employing phenomenological interpretation within the overall process, the researcher was mindful of using a method that would ensure rigorous thematic analysis of the data collected. Thematic analysis was chosen for the present study, using Braun and Clarke's (2006) approach. This method of data analysis is widely used in qualitative studies due to its flexibility in generating insights that not only answer the research questions but also illuminates areas not previously explored in research. This is supported by different researchers using similar approaches to data analysis such as: transcribing the interview in preparation for analysis, familiarising themselves with the data, generating themes through coding and presenting the data (Miles and Huberman 1994; Creswell 2003; Munhall 2012). Thematic analysis has been used in different studies, including McGibbon et al. (2010) and McDonald et al. (2016) and resulted in in-depth insights and information that has influenced policy changes. According to Braun and Clarke (2006 p.79), thematic analysis is a method used for, 'identifying, analysing and reporting themes within a data set'. This process describes a study's data in rich detail. As noted thematic analysis can be used in different ways including examining meanings and experiences arising from human transactions within society. Thus, it is not wedded to a pre-existing theoretical framework. The analysis used in this study followed a process of coding that avoided preconception to ensure that analysis was data driven. This process of analysis has been described as an inductive approach (Braun and Clarke 2006). The primary purpose of this approach is to allow the findings to emerge from the frequent or significant themes that are inherent within the raw data (Thomas 2006). Thus, a 'theme represents something important about the data in relation to the research question' and meaning within the data set (Braun and Clarke 2006 p.82). Inductive analysis was chosen for this study to reveal the MWAs' lived experiences of occupational stress and their coping strategies in answering the research questions.

An illustration of the thematic approach used to analyse the data is presented below.

Initially, the researcher familiarised herself with the data to get a sense of the picture the MWAs were painting within the interviews. This was achieved by listening to the audio recordings and re-reading through the transcripts of the 22 interviews to get a good sense of what the MWAs were saying in their interviews. This helped to immerse the researcher in the data.

The next stage was extracting significant statements from each interview transcript relating directly to the research phenomenon being explored. Codes were assigned to each of the significant statement extracted which illuminated what the MWAs said in the context of occupational stress and coping. Analysing the data in this way ensured that the MWAs' spoke directly for themselves. This was a step towards allowing the potential themes to emerge rather than working through pre-set categories.

The coded meanings were read and re-read to identify potential clusters of themes, drawing together meanings that were similar among the MWAs, revealing key components of their lived experiences within the maternity settings. These clusters were reflected and reviewed in relation to the original transcripts to ensure they represented the lived experience of MWAs. These meanings were highlighted using different colour coding to identify diverse clusters. Once this was achieved the different coloured clusters were collated into emergent, overarching themes. To aid understanding and enhance the analysis process a visual representation of the themes and generated sub-themes was presented (Miles and Huberman 1994)

These themes were then reviewed to ensure the analysis remained close to the MWAs' voice and a coherent pattern evident within the data.

The sub-themes and emergent, overarching themes were then defined and presented within chapters, using direct quotations from the MWAs for illustrative purpose.

A computer assisted qualitative data analysis software package, NVivo, was used to support the analysis and to organise and store data for easier retrieval. NVivo is a data management software that supported the researcher through the process of data analysis. The use of NVivo was limited to ensure that control of the research process remained with the researcher. Despite the time consuming nature of manual analysis, cutting and pasting, working with large amounts of paper and staying fixed to a computer screen, the researcher stayed close and familiar with the data and was responsible for the analysis process. The NVivo software did not contextualise the data, but it proved efficient in keeping track of all data entered and enhanced the researcher's phenomenological analysis.

4.10 Study validity

Different criteria are used to assess the quality of research (Patton 2002). Specifically, for qualitative research using an interpretivist perspective, measures need to be taken to ensure the study applies a high quality methodology, leading to authentic findings. Lincoln and Guba (1985) and Patton (2002) proposed a framework with criteria including credibility, dependability, confirmability, transferability (collectively referred to as trustworthiness) and authenticity, which are used to assess the quality of qualitative research. Trustworthiness in qualitative research also means methodological soundness and adequacy (Holloway and Wheeler 2002).

4.10.1 Credibility

This refers to confidence in the truth value of the data and the researcher's interpretation of it (Polit-O'Hara and Beck 2014). Lincoln and Guba (1985) suggested using two elements to achieve credibility: conducting the study in a way that enhances believability of the findings and taking measures to demonstrate credibility to readers. To achieve this, a detailed account of the study design was provided, including the research method adopted and the justification for their use. Also to ensure the credibility of data generated, participants who were knowledgeable about the research problem and settings were recruited (volunteered). All MWAs that participated had a minimum of 6 months' experience working within the maternity settings. This

was supported by Harper and Thompson (2012). In addition, the findings were presented in a transparent manner using quotes from the interview transcripts and showing the reader a clear process from data collection to data analysis. This ensured the believability of the findings within the study.

Furthermore, to increase the credibility of this study, the interview schedules were piloted with two MWAs. This was to ensure the researcher was asking the right questions during the interviews. The interview schedule contained prompts, which were used to reduce interview bias and assisted the researcher in avoiding asking leading questions that might have led to biased answers. The importance of this was also noted by Kvale (2007) .

Additionally, to promote credibility, the findings were anonymously discussed with the researcher's supervisors.

In order, to enhance credibility a reflective journal was maintained to keep track of decision-making processes and to record initial impressions of the data and themes generated during analysis. This helps to track a researcher's developing constructions, which is critical to establishing credibility (Guba and Lincoln 1989; Robson 2002).

4.10.2 Transferability

Transferability is the extent to which qualitative findings can be transferred to other participants (Bowling 2009; Polit-O'Hara and Beck 2014). Lincoln and Guba (1985) noted that it is the researcher's responsibility to provide adequate and sufficient descriptive data that consumers (readers) can use to evaluate the applicability of the data to other contexts. This was achieved by providing a rich and deep description of the study findings for the reader. This is intended to help the reader decide on the applicability of the research findings in their own context.

To enhance transferability, detailed information relating to the research participants, the selection/recruitment criteria, study settings, data collection method and analysis procedures were also provided. This was to enable the reader to understand the extent to which transferability could be achieved. This implies that providing such rich descriptions would enable the reader to

decide the extent to which this study's findings are applicable to the wider population or would fit another situation, as described by Guba and Lincoln (1989). This position is also supported by Willig (2013).

4.10.3 Dependability

According to Polit-O'Hara and Beck (2014), dependability refers to the stability of data over time and conditions. This implies the extent that study findings could be repeated if the inquiry were replicated with the same participants on a different occasion (Robson 2002). Furthermore, Polit-O'Hara and Beck (2014) noted that in the absence of dependability, credibility cannot be achieved. Streubert and Carpenter (1999) also noted that dependability is a criterion that is met once a researcher has determined the credibility of the findings. To this end, the researcher achieved credibility as detailed above, and hence dependability was achieved.

However, Holloway and Wheeler (2002) and Lincoln and Guba (1985) also suggested that an audit trail is necessary to achieve dependability. This means that readers are able to evaluate the adequacy of the analysis from the decision-making process of the researcher through to how the conclusions were achieved. Hence, to ensure dependability of a study's findings, they should be accurate and consistent (Holloway and Wheeler 2010). The researcher achieved dependability by keeping an audit trail, which involved maintaining all transcripts, notes and audiotapes used in data collection, with a clear outline linking the data collected to its anonymised source. In addition, the operational details of the field work were also given, including decisions made before and during the research. This audit trail also represented confirmability within this study.

4.10.4 Confirmability

Holloway and Wheeler (2002) also noted that confirmability is attained when a reader can trace data to the source and follow the researcher's path to the themes and interpretations that emerged. This again, implied having an audit trail. To achieve confirmability, Polit-O'Hara and Beck (2014) advised that the study's findings must reflect the participants' voice. Thus, the researcher

ensured that both participants' and researcher's voices were evident in writing up the finding. Additionally, Thomas and Magilvy (2011) noted that when credibility, transferability and dependability have been established, confirmability has occurred. Furthermore, to enhance confirmability, the researcher engaged in reflexivity. This was identified as the researcher's voice within the study where applicable.

4.10.5 Authenticity

According to Guba and Lincoln (1989) trustworthiness relies on the methodological adequacy of the research; however while this is useful, they felt it necessary to include the additional component of authenticity. Thus, the authenticity criterion was devised and added to ensure rigour in qualitative research. Guba and Lincoln (1989) and Creswell (2003) suggested that to achieve authenticity the researcher needs to engage in fairness in both reporting and representing findings. This is to ensure the participants' experiences are reported in such a way that respect for the context of the data is maintained. This suggestion was adopted by the researcher and the findings were presented using the MWAs' quotes to support points made within the study. Furthermore, the researcher ensured the findings were presented using the MWAs' statements where possible to help readers better understand the lived experiences being depicted.

4.11 Ethics and ethical theories

The issue of ethics has been debated within the literature based on conflicting ideas of rights, claims and competing responsibilities within research (Kvale 1996; Mauthner 2008). Despite these debates, the issue of ethics cannot be ignored. Hence, Kvale (1996) identified three ethical models/theories (deontology, consequentialism and virtue ethics of skills) aimed at providing a framework for assessing the implications for conducting research. Although, a debate of these theories is outside the scope of this thesis, their principles are summarised in Appendix 15. The main principles within ethics are autonomy, beneficence and non-maleficence, justice, respect and dignity of the individual (Cluett and Bluff 2006). These are similar to the key principles identified by Beauchamp and Childress (2009): autonomy, beneficence, non-

maleficence and justice. These principles were used to guide the ethical considerations within the study and are summarised below.

Respect for autonomy - The principle of respect for autonomy relates to acknowledging a research participant's right to hold views, make choices and take action based on their values and beliefs (Beauchamp and Childress 2009). This implies respecting the decision-making capacities of research participants (Beauchamp and Childress 2009). This enables individuals to make informed decisions on whether or not to participate in a study. This principle was applied to this study by obtaining relevant permission from the hospital senior management and the MWAs through informed consent (see 4.11.2.1). The issue of informed consent is detailed below. It also extends to the choice a participants has to withdraw from a study at any point.

Beneficence and non-maleficence - Polit and Beck (2006) described beneficence and non-maleficence as maximising benefits to the research participants and minimising the potential for any harm occurring to any participating individual. Therefore, a researcher has the duty of assessing the potential for any harm to either the participants or researcher and of taking every step to guard against it. Holloway and Wheeler (2002) advised that a study is not ethically justified if the potential to cause harm exceeds the intended benefits. Furthermore, Beauchamp and Childress (2009) emphasised a researcher's obligation to abstain from causing any harm to individuals within a study. Hence, every research participant has the right to freedom from harm or discomfort. Polit-O'Hara and Beck (2004) identified that harm could be physical, psychological or financial. While it was envisaged that no physical harm could come to the MWAs as a result of this study, psychological harm could not be completely ruled out due to the context of the research. In addition, due to the flexibility of the research method (interviews) adopted within this study, emotion could be evoked as the participants might choose to relate some sensitive experiences. In this study, if any of the MWAs showed any signs of psychological distress this was to be addressed by debriefing the MWAs following the interviews. The MWAs were not at risk of physical or financial loss as the interviews were conducted within their

workplace. In addition, confidentiality and anonymity were also considered important to ensuring no harm occurred to the MWAs. These factors are discussed below in the section on ethical interactions with MWAs.

In relation to the perceived benefit for the MWAs, this was regarded as being able to share their experience with someone (researcher) who was interested in and concerned about their health and well-being. Another benefit was that the study aimed to improve the MWAs' work experiences by making recommendations to alleviate the effects of stress within the maternity settings and for others facing similar experiences.

Justice - Justice is the fourth ethical principle identified by Beauchamp and Childress (2009). This implies treating research participants fairly and equally. In this study, the risk of unequal treatment was very minimal. Participation in this study was voluntary and MWAs who did not take part were not discriminated against. In addition, there was no opportunity to offer any preferential treatment to MWAs who participated in this study and individuals who did not take part were not disadvantaged in any way.

4.11.1 Ethical consideration

Regardless of the approach to qualitative research adopted, ethical considerations needed to be given full consideration throughout the research process from study design to publication of results (Mauthner 2008; Creswell 2013). This was supported by the Brinkmann and Kvale (2005) argument that qualitative research is saturated with ethical issues, not only in relation to the effects of human interaction, but also at the very beginning when formulating the research questions. Hence, they suggested that a researcher must remain ethically attuned through the research process. In qualitative studies, the research questions identify a phenomenon the researcher wants to explore and seeks answers that provide detailed descriptions (Gregory 2003). In view of this the researcher gave consideration, to whose interest it was to ask the research questions, the knowledge to be produced and for whom it was produced. This corresponds to reflexivity (adopted within this study) whereby personal and professional motives were identified throughout the research

process thus influencing the philosophical and methodological decisions to be adopted to answer the research questions (Cluett and Bluff 2006).

In view of the philosophical underpinnings including feminism, ethical concepts as described by feminist philosophers, Gilligan (1982) and Noddings (1984) were considered. Both argued for the inclusion of an 'ethics of care' component which characterises the moral decision-making used by feminist researchers (Bergman 2004). Noddings (2003) suggested that women focus more on the relationships between people and not just the rules, norms or laws that might operate in a given situation. An 'ethics of care' begins with what is believed to be common to all humans, a longing for goodness (Noddings 2003). This relies on the capacity for empathy and a receptiveness to the experience of another that is both affective and cognitive (Preissle and Han 2012 cited in Hesse-Biber 2012). While the feminist 'ethics of care' is still being debated within philosophy, the concept of caring proposed by Noddings (2003) has been criticised. These criticisms are based on the assertion that women are all the same, ignoring individual differences and experiences, and without any consideration of the role of power in relationships (Bergman 2004). Although the debate on the feminist 'ethics of care' is outside the scope of this thesis, a feminist approach to ethics is a commitment to continually reviewing and challenging notions of what are appropriate and reliable ways of knowing and understanding the world being researched (Ackerly and True 2010). While the ethical principles outlined earlier were taken into consideration in this study, feminist ethics further drew the researcher's attention to the need to be critically aware when conducting research in a female dominated environment. This meant addressing the challenges, research developments and, crucially, the diversity among women that may be encountered, as well as accurately presenting the lived experiences of the participants (Hesse-Biber 2012).

Thus, in determining the way in which participants were recruited, ethical consideration was given to the adopted approach. This was to ensure that participants were not pressurised to partake in this study, thus re-iterating the concept of voluntary participation. Data analysis and dissemination of results were aspects of the study considered to be conducted ethically. Cluett and Bluff (2006) and Willig (2013) argue that researchers need to be conscious of

modes of analysis to ensure data is interpreted to reflect the participants' accounts of their experiences, especially where participants have access to the research report and can read how their data has been analysed.

4.11.2 Ethical interactions

Ethical considerations during interactions have been grouped into procedures relating to informed consent, deception and confidentiality which, if properly adhered to, minimise the potential of any harm occurring (Creswell 2013). However, ethical considerations are not limited to protecting participants from harm but include delivering positive benefits to participants (Willig 2013). For instance, presenting opportunities with knowledge gained to solve or make recommendations, to resolve identified problems.

The following strategies were used to address ethical issues during the interactions between the researcher and MWAs over the period of the study. Before approaching potential hospitals and MWAs, the researcher went through the University's ethics procedure and submitted the completed ethics forms as well as required documentation including the interview schedule. This study was granted ethical approval on 18 February 2015 by the chair of the Humanities, Social and Health Sciences Research Ethics panel. The process of undertaking the ethical approval helped the researcher think more thoroughly about carrying out the study and what would be involved. This was very helpful as the researcher was able to prepare carefully, consider the best approach, while bearing in mind the sensitive work environment and the participants involved. The ethical process enabled the researcher to learn how to be more thorough and constructive in conveying information that justifies the essence of the study when responding to feedback on the why and how questions. Additionally, the researcher was able to spend quality time to think of the flexibility required in face of the *what if* situations. This was indeed an intense and very useful process.

4.11.2.1 Informed consent

According to Silverman and Marvasti (2008), informed consent is described as giving the required information about the research to a subject in a form that

is easily understandable in order to aid their decision on whether or not to participate. Therefore, the researcher gained informed consent prior to each interview. Individual consent was sought from the voluntary participants. The process of achieving this included the MWAs signing and dating the consent form, and is detailed in section 4.8. Information about the research, how it would be conducted, their right to voluntary participation and strategies for ensuring anonymity and confidentiality are detailed in the information sheet provided to the MWAs.

Furthermore, a verbal reiteration of informed consent was undertaken with the MWAs before the actual interview (data collection) began to build their trust in the study and ensure any residual ethical issues were dealt with. In addition, voluntary participation was achieved by checking with the MWAs at different points in the interview to check whether they were happy to continue with the interview. Bowling (2014) supported achieving voluntary participation as this safeguards an individual's freedom to choose to participate or not.

4.11.2.2 Anonymity

The participants' identities were restricted to the researcher. To ensure anonymity was enforced, participants (MWAs) and hospitals were allocated unique alphabetic (pseudonyms) and numerical codes. These were used by the researcher to link the MWAs with their location for ease of analysis. Information shared with associated personnel (e.g. researcher's supervisors) was strictly limited to anonymised data. In addition, participants had the opportunity to read the interview transcripts to check that their anonymity had been fully protected. Furthermore, consideration was given to names of people (mothers or staff) mentioned within the interviews by MWAs. These were edited out of the transcripts to ensure ethical procedures regarding anonymity were fully adhered to when reporting findings in Chapter 6. Exploration of this aspect of confidentiality formed part of the ground rules during the interview session.

4.11.2.3 Confidentiality

All biographical details collected were separated from other study documents. This was supported by Ritchie et al. (2014), emphasising the need for everything possible to be done to ensure participants were not identified within a study. Hence, the interview transcripts (anonymised) and consent forms were also stored separately in a locked facility within the researcher's office with access restricted solely to the researcher. The interviews were recorded using a digital recorder (permission was granted). The recordings were copied from the recorder to the researcher's computer as a password protected file for analysis. This was also backed up on a password protected storage device for the duration of this study. The digital recording was stored in a locked drawer to which only the researcher had access. This recording was listened to only at secure times and locations to ensure that confidentiality of data was maintained and this will be destroyed when the study has ended.

4.11.2.4 Researcher's safety

The researcher's safety was assessed based on the agreed location where the interviews with the MWAs were to be conducted. Therefore, every measure was taken to ensure that the potential for any harm to personal safety for the researcher was minimised. For instance, the researcher agreed mutually convenient times for the interviews. Consideration was also given to the researcher's journey times in order to minimise the need to travel from interview locations late at night due to security concerns in Nigeria. As this research was conducted outside the UK, the researcher ensured that contacts (within both the UK and Nigeria) knew the researcher's whereabouts during the period of the interviews. Effective means of communication with the researcher were available, including a mobile phone number in case the need arose. A family member was also aware of the researcher's location (hospitals) and the proposed duration the researcher was expected to be there for. On completing the interviews and leaving the hospitals, the designated person was updated with this information. The researcher's supervisors were also made aware of the researcher's movements at intervals and updated as the interviews progressed via emails and Skype sessions.

4.12 Excerpts from my reflexive diary

Engaging in reflexive practice was an important activity that made me stay truer and closer to the MWAs' voices. Had reflexivity not been applied, it would have narrowed the explanatory value of the concepts and lived experiences of the MWAs that were subsequently revealed. This also implied staying true to the philosophical principles guiding the present study. Reflexivity is an important aspect from the key standpoints of the study which was informed by interpretivist, feminist and phenomenological perspectives to ensure self-awareness during the research process (Parahoo 2006, Polit and Beck 2006). Furthermore, the combination of these perspectives added value to the perceptions of the MWAs' role and lived experiences that would otherwise not have been invisible within the research.

Reflexive Account: Research Stage Methodology

I had an aspiration to explore in-depth the MWAs' perception of stress and coping and, their lived experiences working within the maternity setting. Having considered the different approaches in depth I chose to undertake a qualitative research study. Although I did explore the idea of using a mixed method approach, I concluded that given the cultural differences between my chosen setting and the locations where validated tools where created and widely administered, a mixed method approach would not yield helpful data. Also, as there is little known about the group of women (MWAs) who play a key role within the maternity services, hence there was a need for an explorative study.

Nevertheless, despite my limited experience with qualitative methods I was determined to overcome this and develop my skills.

I have adopted an interpretivist approach because the main aim of this present study is to explore the lived accounts of MWAs within the maternity setting. This I believe is appropriate because I do not subscribe to the view that knowledge can exist independently of human thoughts. Even though this is my belief, throughout the research process I needed to be clear I was not imposing my own preconceptions but staying close to the lived experiences of the MWAs.

Reflexive Account: Pilot study

I maintained a reflexive account during the course of the pilot study and an extract is included below:

I have to confess I was nervous today, approaching for the first time, one of my study sites. This apprehension derives from the knowledge of how some organisations perceive Nigerians studying abroad and returning to collect information about their practices. Not gaining research access was therefore a distinct possibility and I therefore recall my initial visit to one of the hospitals and this helped settle some of these reservations as I received a warm welcome and very positive interest in my research proposal.

It felt like the MWAs were already prepared for a researcher to talk to them. Although there was no prior relationship between the researcher and the MWAs, their willingness to be frank about their work experiences and reveal personal information was overwhelmingly generous. I felt this willing acquiescence was more than just the MWAs feeling comfortable with certain aspects of the study such as anonymity and confidentiality but that they had trust in the fundamental motives of what the research was trying to achieve. Also, it was evident that my ability to speak the local language increased their confidence. At this point I was feeling optimistic about the interview process and felt the ice had been broken. This settled my prior uncertainties about their initial reaction of being interviewed by a Nigerian student studying abroad who was not a MWA herself.

Reflexive Account: Data analysis

My data analysis, informed by validated methodological approaches, was conducted to ensure the voice of the MWA was clearly heard. I have not worked as a MWA or worked as a professional in the maternity setting so, unlike the MWAs I did not have any experience that was similar to theirs. The MWAs voice was paramount and to this extent and within the context of the study the powerbase lay with them.

I did not have to struggle to set aside my preconceptions or previous experience and was able to freely listen to the stories of the MWAs. This made me more aware of my position as I began to analyse my data. As I

began to analyse my data almost every statement had a significant memo attached to it.

4.13 Summary

In summary, this chapter provided a detailed discussion of the methodology and methods adopted to undertake this study and the justification for their use. This demonstrated how the research design and methods supported the achievement of the aims and objectives of this study and furthermore, addressed the focus of the research questions. This chapter also examined the philosophical underpinning adopted. Interpretivism provided a suitable philosophical underpinning for the study, further justifying the methodological approach adopted. An overview of phenomenology was also provided to aid an in-depth understanding of the specific qualitative approach adopted for this study. The strengths and limitations of phenomenology were discussed, aiding the rationale for implementing this approach. This chapter also assessed the quality of the study and its findings. In the context of this study, as a qualitative research that used a phenomenological approach, the principles of trustworthiness provided by Lincoln and Guba (1985) were adopted. These principles included credibility, dependability, confirmability, transferability and authenticity. These also helped to provide readers with the required information to assess the credibility or transferability of the study's findings.

This chapter discussed the sampling approach adopted to recruit the MWAs for this study and the inclusion and exclusion criteria used to ensure the right voluntary participants were recruited to the study. A detailed account of how the field work progressed, including the interview sessions, was also provided. The approach to data analysis was detailed above. This allowed for the emergence of themes from the interview transcripts rather than imposing themes on the data.

Finally, the ethical considerations applied to this study were outlined. This covered a wide range of concerns, including research design, transparency, participant's well-being, confidentiality, anonymity and researcher's safety. Ethical considerations were applied to this study at all times, from formulating the research questions to selecting the phenomenological approach which

was largely dependent on the participation of carefully recruited individuals (MWAs). Beneficence and non-maleficence were carefully considered to ensure the MWAs were not exposed to any harm and had the potential to benefit from this study. All the MWAs were treated fairly, with no preferential treatment offered for partaking in the study, and participants who did not take part in the study were not disadvantaged in anyway. The next chapter presents the study findings from the interviews conducted with the MWAs.

CHAPTER 5 STUDY FINDINGS

5.0 Introduction

The aim of this study was to explore the maternity ward attendants' (MWAs) perceptions of occupational stress, possible cause(s), the impact and support and the coping methods they adopted within hospital (maternity) settings in Nigeria. This chapter provides an overview of the data generated from analysing the transcribed interviews conducted. The approach to data analysis and methodology used are detailed in Chapter four. Additionally, thoughts and issues which emerged during data collection were noted in the researcher's diary and presented in Chapter four. The findings generated from this data analysis will be used to answer the research questions posed in Chapter One. Quotes from the 22 MWAs' interview transcripts will be used to support and illuminate the themes which emerged.

The research questions explored four main areas, which, following analysis, generated different themes. These themes describe the most important aspects of the MWAs' lived experiences of occupational stress, together with the coping mechanisms they used. The themes best describe the overarching experiences of occupational stress which the MWAs talked about passionately. The key themes which emerged from the four main areas explored include sub-themes (See Table 2).

The sub-themes are the result of further, in-depth analysis of the transcripts and provide a deeper understanding of MWAs' experiences within the context of work and home life. These themes contribute to new knowledge about stress among MWAs and coping strategies hitherto not reported in the literature.

The MWAs' experience of occupational stress was the first area explored with the respondents. The findings mainly described the meaning participants ascribed to and the type of conversations they had with their colleagues about occupational stress. This provided a context of what formed MWAs'

understanding of stress from their perspective and within the context of the Nigerian culture.

The second area the researcher explored concerned the sources occupational stress/work stressors for MWAs. The MWAs identified an array of work stressors experienced within the maternity setting and these were cited by most of the MWAs interviewed across the three hospitals. The MWAs noted the main causes of stress were work overload, lack of adequate support, staff shortages, exploitation by senior staff and inadequate facilities/resources. The analysis revealed there were overarching themes that linked to the wider literature and included: work organisation, work intensification, professional working relationships, administrative issues and environmental, and human resource management factors. These themes are underpinned by the individual stressors/sub-themes identified by the MWAs.

The third area explored within this study was the impact of occupational stress on MWAs. The MWAs working across the three hospitals described very similar conditions because of their constant exposure to the different sources of stress. In most cases, the MWAs described the impact in terms of their reactions to stress. Most of the MWAs reported body aches, headaches, feelings of suffering and anxiety, frustration and low self-esteem. Four key themes emerged: emotional, behavioural, physical and social impact of occupational stress. These themes are underpinned by different sub-themes/individual reactions identified by the MWAs.

The fourth key area examined was the support available and the coping mechanisms adopted by the MWAs within the maternity settings. The MWAs described relying mainly on their colleagues for support within the hospital. Only a few of the MWAs identified receiving any form of support from senior members of staff and when they did this was mainly from midwives. However, common to all the MWAs was the support they received from family members at home. The research also explored the coping mechanisms adopted by the MWAs and these included sharing their work stress with colleagues or relying heavily on medication to alleviate the effect of occupational stress.

This chapter is organised into five sections. The first section provides the descriptive statistics representing the biographic characteristics and MWAs role/job descriptions. However, It is worth noting that the researcher left percentages in the biographical data section to give a sense of the commonality of occurrence among this specific population of MWAs.

The second section presents the findings of the MWAs' experiences of occupational stress. The third and fourth sections outline the sources of stress and the impact of occupational stress respectively. Finally, the fifth section examines the coping mechanisms and support available to MWAs within the maternity settings. This chapter concludes with an overall summary of the five sections presented.

Table 2: Structure of the four areas and corresponding themes and sub-themes

Key areas explored and overarching themes	Sub-themes
1. **Experience of occupational stress** 1.1 Meaning of stress 1.2 Identifying stress and how often MMAs felt stressed at work 1.3 Comment and conversations on stress with other colleagues 1.4 Employer's policy on occupational stress.	
2. Sources of occupational stress among MWAs. 2.1 Work organisation/organisational factors	2.1.1 Shift patterns and long working hours 2.1.2 Work overload and role expansion 2.1.3 Role expectation, poor staffing levels and staff shortage
2.2 Professional working relationship	2.2.1: Lack of consultation and staff input 2.2.2: Lack of respect from senior staff and recognition as part of a team 2.2.3: Exploitation by senior staff 2.2.4: Poor relationship with management 2.2.5 Lack of support/ understanding from senior staff/management
2.3 Resources and governance	2.3.1: Inadequate equipment and shortage of resources 2.3.2: Lack of meal breaks and control over times
2.4 Environmental factors	2.4.1: Exposure to infections 2.4.2: Chaotic and hazardous working environment

	2.4.3: Poor infrastructure/ Unfit MWAs' base
2.5 Organisational/human resource management factors	2.5.1: Poor remuneration, salary discrimination and lack of reward/incentives 2.5.2: Lack of career and growth opportunities: 2.5.3: Politics/discrimination in recruitment and advancement:
3. Impact of occupational stress on MWA 3.1: Emotional and psychological impact	3.1.1: Low self esteem 3.1.2: Feeling anxious 3.1.3: Feelings of suffering 3.1.4: Feeling helpless 3.1.5: Feeling frustrated: 3.1.6: Feeling de-motivated 3.1.7: Feeling undervalued
3.2: Behavioural impact/reactions	3.2.1: Over reliance on pain killers (analgesia) 3.2.2: Cranky and snapping at colleagues
3.3: Physical reactions to stress	3.3.1: Body aches 3.3.2: Sweating profusely and high body temperature
3.4: Social impact	3.4.1: Withdrawn from family 3.4.2: Restricted social life 3.4.3 Impact of future career: too stressed to plan ahead

4. Coping mechanisms and support 4.1: Keeping work stress to myself/self-support and pretend to cope 4.2 Sharing work stress with colleagues and family members (Support from colleagues and family members) 4.3: Sharing work issues with senior staff 4.4: Prioritising workload, casual breaks and sugary refreshment 4.5: Calling on God	

5.1 Biographical characteristics and Maternity Ward Attendants role/job descriptions

The MWAs were employed by the Health Service Commission (HSC) in Nigeria and worked within the federal hospital system. The HSC is responsible for Human Resources within the health sector. Initially two hospitals were identified for this study, but a third hospital was included as the field work unfolded. The opportunity to include a third hospital in this study arose as a few of the participating MWAs from the first two sites made reference to colleagues experiencing similar situations at the third site. Hence, the researcher seized the opportunity to include a third hospital site to further explore the concept of occupational stress. The researcher ensured ethical considerations were followed at the third hospital as with the other study sites (See Chapter four). The findings from the three hospitals were similar with some minor differences which did not warrant identifying the sites individually although, references to some of the differences will be made throughout. Anonymity is also applied to the participants with each being given a pseudonym that avoids identifying them or where they work. All the data is aggregated together and presented in the descriptions and subsequent discussions in this thesis.

Despite operating under an overarching body namely the HSC, there were some inconsistencies in terms of the MWAs' roles and duties across the three hospitals. The three hospitals differed in their approach to work organisation and employee management. Two of the hospital sites had a large number of maternity deliveries and therefore needed a high number of MWAs. The third hospital was slightly smaller compared to the other two participating sites. However, it shared significant similar characteristics with the other two sites and was therefore included in this study.

From the data analysis, one of the hospitals had more modern equipment, including a lift to assist in the smooth transportation of mothers and babies, compared to the other hospitals where they relied on sloping stair ways to

transport women between floors. The lack of equipment was highlighted by the MWAs in the hospitals that did not have a lift facility as something essential which would greatly improve their work experience. However, the hospital that had a lift had a poor maintenance culture and lacked an adequate power supply that meant lift was sometimes less effective than might be expected. Riniuola confirmed;

> ''….ahh but when there is no light (power supply) in the hospital and when there is no light the lift will not work….''

Another difference between the hospitals was that one hospital employed a few male porters to assist the MWAs in transporting mothers to different floors and areas not restricted to female staff in the maternity hospital. The second site also had male porters in the hospital but in very limited numbers so the MWAs still had to do some of the heavy lifting, which the MWAs complained about. The third hospital site did not employ any male assistants, thus leaving the MWAs to undertake all the transportation duties.

Many of the MWAs described being employed in a variety of jobs before starting work in the maternity service. Some of the MWAs worked as petty traders while they waited to secure a MWA job. Whilst others had jobs in other hospitals within different departments before being transferred to the maternity setting. For instance, Bolutife described working previously in the general medical ward. She said;

> "I have worked on this ward (maternity) since year 2000 but they (management) usually transfer us sometimes to different wards, I worked in the general ward in 2013 but shortly after I was transferred back to this maternity ward again……".

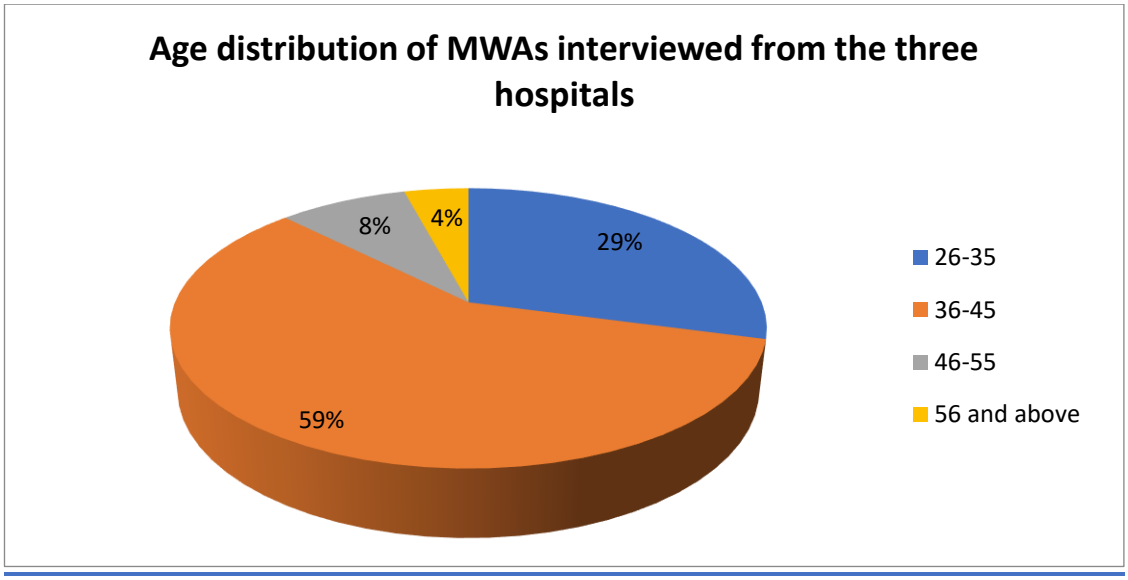
The educational background of the MWAs was explored during the interview and the findings showed that it varied although the majority of the MWAs were not educated beyond O' levels. Four of the MWAs had national diplomas, 13 had secondary education certificates while the remaining 5 had some form of elementary/primary education. Whilst the requirements for this role was not well specified within the public service rules, recently some hospitals

introduced the requirement for new MWAs to have as a minimum a secondary school qualification.

5.1.1 Biographical data of Maternity Ward Attendants

In total 22 interviews were conducted and transcribed verbatim. 11 MWAs from the first, 7 MWA from the second and 4 from the third hospital participating in this study. The characteristics of the population (MWAs) within this study will be presented graphically below.

Diagram 2: Age distribution of MWAs



A total of 29 per cent of the MWAs were aged between 26 and 35 years. Fifty-nine per cent of MWAs were aged between 36 and 45 years and eight per cent were between 46 and 55 years old while respondents aged 56 years and above represented four percent of the total respondents (N=22). The findings indicate that the majority of MWAs in the three hospitals were between the ages of 26- 45.

All 22 MWAs who participated in this study worked full time. The MWAs explained that flexible working was not available and staff did not have the option of working part-time.

Diagram 3: Length of time working as MWA

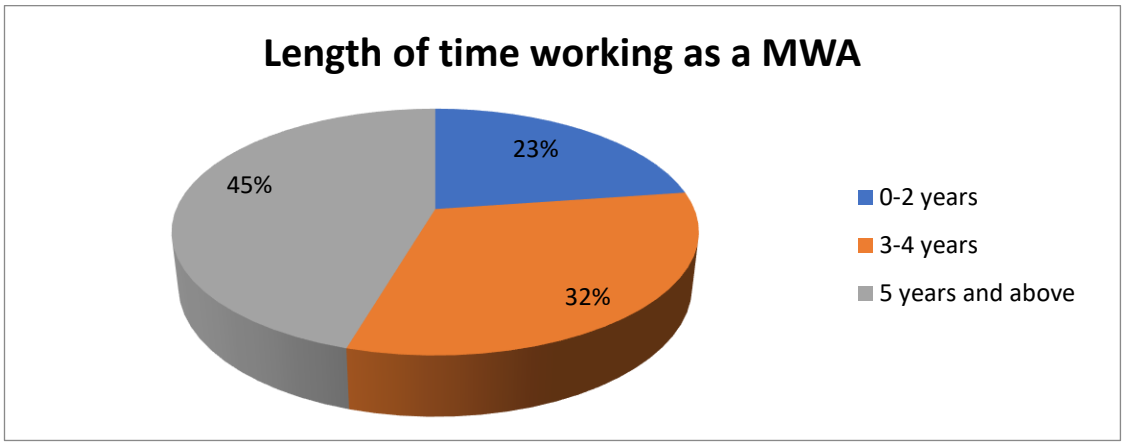
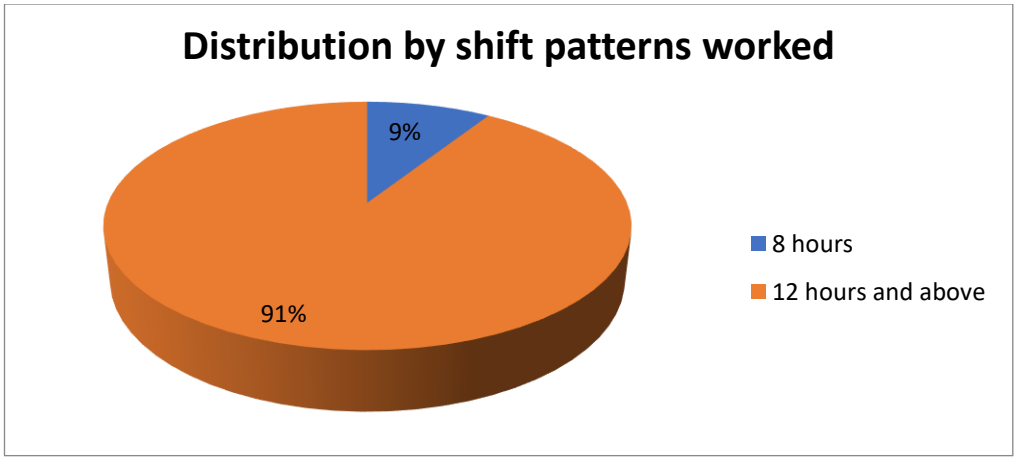


Diagram 3 (above) shows that 45% of the MWAs had over 5 years working experience in the maternity setting, while 32% had between 3-5 years and 23% had a minimum of 6 months experience. One of the oldest MWAs interviewed was aged over 56 years and had over 10 years' experience in the maternity setting. Similarly, one of the MWAs within the 36-45 age group had over 14 years' experience as a health attendant, but only 7 years located in the maternity setting. This highlights the vast experience some of the MWAs had within the maternity setting.

Diagram 4: Distribution by shift patterns worked



The majority of MWAs (91%) worked 16 hour shifts and this included a combination of night and morning shifts, while only 9% worked 8 hours permanent morning shifts. The MWAs did not have the option to work

permanent night shifts. However, the MWAs working on permanent mornings did have their shift changed to cover different areas within the maternity unit if there were staff shortages, for instance staff on leave.

5.2. Role/Job description

At the outset of the interviews, the MWAs were invited to talk about their role within the maternity settings. The aim was to obtain a general description of some of the activities the MWAs were engaged with during their shift. The MWAs described their role and the tasks they carried out using a variety of descriptions. The most common duties included general cleaning, sweeping, mopping, collecting patients' plates, running errands for pregnant women/new mothers and doctors/nurses, and also being present in the labour ward. The tasks identified by the MWAs from the three different hospitals were similar. The mandatory duties of MWAs in one hospital included transferring patients between the wards and other departments within the hospital, for instance, when a pregnant woman needed a scan or any form of assessment. This was one of the inconsistencies between the hospitals as this site did not employ male porters to assist the MWAs in transporting mothers compared to others that employed a few. Some excerpts from the interview transcripts highlight the discussions around role descriptions. For instance, Dayo said;

> "When I resume in the morning, I start by sweeping the wards, doctor's rooms, labour ward if it is not in use at that time. I also empty the bins. I will mop the whole floor.....Then I move to collecting patients' plates.....take it to the kitchen to get it ready for their food. If a mother needs something and she calls me I will help her go and get it...I also collect midwife's report book ....."

Over time the work has evolved with MWAs taking on more duties, for example kitchen work and cleaning. Wonuola noted;

> "long time ago the work was not like this. There used to be more staff, there were cleaners so the work was not plenty. We will just be doing our own attendant work but now we (MWAs) do everything, including cleaning".

Another MWA described her role differently and highlighted the negative consequence of having to do more work and the stress this caused. For instance, Ifeoluwaposi remarked

"….it is the attendants (MWA) we are plate pickers …".

Ifeoluwaposi compared her role as a MWA to that of a plate collector from the kitchens. When needed the MWA took on this duty and washed patients' plates ready for their next meal. Although this was not originally part of her duties, due to staff shortages in other departments the MWAs now had to collect the patients' plates. Some MWAs described just collecting the patients' plates and taking them to the kitchen and a few explained they also have to serve the patients' meals to them. These comments illustrate how the MWAs' role has expanded or evolved due to staff shortages in other departments. This issue is discussed further in Chapter six. Other inconsistencies in duties/roles were highlighted across the three hospitals. The MWAs in two hospitals discussed taking the midwives' end of shift report book from one office to the other within the maternity ward. At the third hospital this was not part of a MWA's duty. However, at all three hospitals the MWAs were involved in collecting blood from different laboratories. In the event that a particular type of blood was not available within the hospital, the MWA described going in the ambulance to collect the required blood type. One of the MWAs also compared her job to a production line. For instance, Aduoluwa said;

"It is like you are working in a factory."

The MWAs also described working with an array of senior staff including attendants' coordinators, nurses, midwives and doctors who they are all answerable to within the maternity setting. Despite the MWAs taking on more work they stated that no one was taking any duties off them. This will be elaborated on within the discussion.

During visits to the hospitals, the researcher noted that MWAs in one hospital were more involved in physically challenging activities compared to those in the other hospitals. For example, during one of the researcher's visits, a MWA

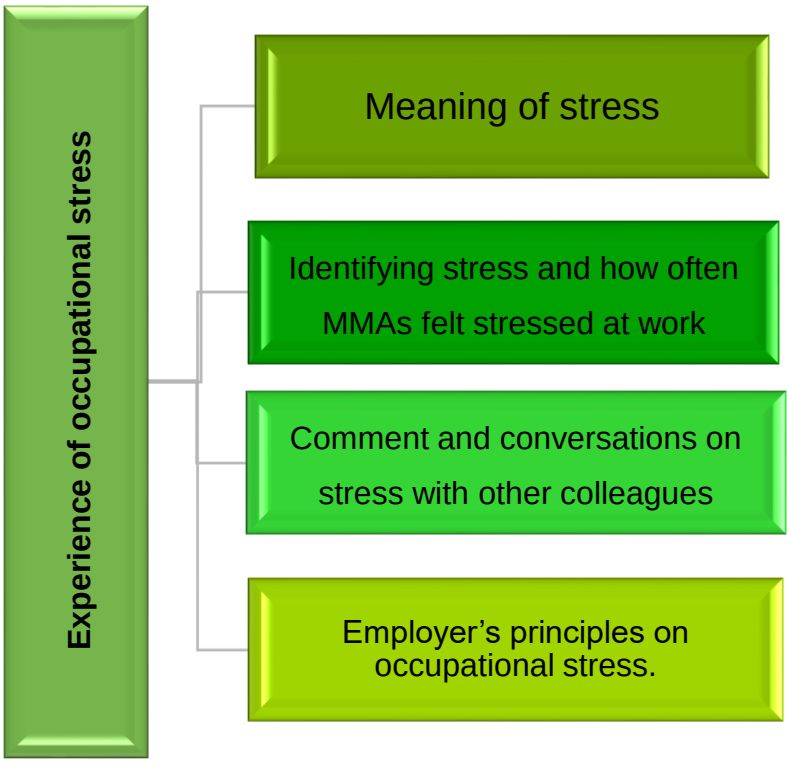
due to finish her shift (confirmed on enquiry) was seen transporting dispenser bottles filled with water on her head to the doctor's room. In another hospital, a MWA was seen struggling to drag a heavy bin towards the lift, while on another occasion the MWAs used broken wheel chairs to transport heavy bins out of the building.

In summary, the participants (MWAs) were permanent staff, working full-time. There were two shifts either 8 hours (morning) or 16 hours (night) and the MWAs worked a combination of both. The MWAs had various educational backgrounds and were diverse in age. The youngest of the MWAs was 26 years while the oldest was aged over 56 years. The roles of the MWAs varied within the different hospitals, the variations were typically based on the differences between the senior staff they worked with and the type of leadership style adopted. Inconsistencies in roles/duties across the three hospitals and wards were evident from the discussions with the MWAs. Some of the MWAs presented themselves as the pillar of the workforce within the maternity settings due to their level of experience and length of service.

5.3 Maternity Ward Attendants' experiences of occupational stress

This section describes the MWAs' perceptions and experiences of occupational stress. Four themes emerged from the analysis and illustrate the MWAs' understanding and experiences of stress. Diagram 5 shows a graphical representation of the themes which emerged from exploring this area.

Diagram 5: Themes emerged from MWAs experiences of occupational stress



5.3.1 Meaning of stress

The MWAs initially described what stress meant to them and outlined their personal experiences. All the MWAs were quite familiar with the word 'stress' and had a general understanding of the meaning of occupational stress. Consequently, the MWAs did not require the researcher to explain the term. In addition, the MWAs also recognised and understood what occupational stress meant within the maternity setting. This understanding was evident from the expressions and responses to interview questions, indicating that MWAs constructed their meanings from their daily experiences of stress within the maternity settings.

The MWAs provided interesting and poignant descriptions of stress. Some described their work as stress in itself. Eniola commented;

"Stress, ah stress is every day in this work. The work is stress".

The MWAs considered their work as stressful because the maternity wards were busy irrespective of the shift (morning or night). Therefore, a combination of busy shifts without breaks and the impact of this informed MWAs' descriptions of stress. Some quotes extracted from the interviews presented below illustrate the meanings MWAs attached to stress.

Labake gave a clear description in terms of what she feels when stressed. She stated;

> "ahhh stress I....when I am feeling tired, after working since morning (start of a shift) and I am beginning to really feel tired, then I know I am stressed because these wards are busy even if it is during the night shift it can be busy too."

Dayo also explained;

> ".... stress to me is when I am just exhausted and I feel my body is not mine anymore. My joints are aching and I feel so weak within myself. This happens before half of the shift is gone because I have just been all over the place doing one thing or the other."

Based on the experiences illustrated above, MWAs perceive occupational stress as a condition caused by their work environment and excess work duties that puts an enormous amount of pressure on them. The stress was manifested in physical or emotional symptoms.

5.3.2: Identifying stress and how often MWAs felt stressed at work

The MWAs were able to identify when they were experiencing occupational stress and provided different views of how they recognised feeling or knowing they were stressed at work. The symptoms which signalled stress to the MWAs ranged from feeling weak, dizzy, having headaches, body aches and joint aches to list a few (see Physical impact). For instance, Adunoluwa explained;

> "It is when my body begins to hurt seriously and ache to the bone. In fact, I feel dizzy sometimes when I am working".

Olaoluwa described a different experience of being stressed. She said;

> "… my body was aching me to the bone seriously ahhh I knew yes…. that when I am so stressed like that tears will be dropping from my eye..."

Many MWAs linked the effect of stress either with a physical reaction or a change in their mood (emotional reactions) which enabled them to recognise they were stressed. The effect of occupational stress will also be explored and discussed later within this chapter.

The participants described feeling stressed at work on every shift due to the enormous amount of work they were required to do in the maternity ward. Most of the MWAs also listed different symptoms of stress while describing their experience of being stressed at work, as stated above. Excerpts from the interview transcripts highlights further the frequency with which MWAs felt stressed on their job. Gbemisola indicated;

"I feel stressed at every shift due to how busy the ward is always."

Ifeoluwaposi also stated;

> "…stress is experienced everyday on this job. Just like I mentioned earlier, imagine me getting home and unable to do anything at all. It is like an extra effort going to have my bath."

The MWAs had different experiences of occupational stress and there was a general consensus that taking time off work due to stress was viewed negatively by management. The MWAs explained this was a taboo subject because the management were opposed to MWAs having time off for any reason, even if it was work related stress.

The issue of 'taking time off work' was explored further to ensure there was an understanding of what it meant. A probing question was used to ascertain if the MWAs had taken time off work due to work related stress? The MWAs responded differently; however, the majority described it as something that was impossible, must not happen and was prohibited. For instance, Kitan reported;

"ehn time off!!! There is nothing like that in fact if I am passing out like this I better be at the hospital or someone is dragging me to the hospital oh. They do not want to hear you're not feeling fine so you stay at home. Stay at home to do what? Ehn it cannot happen you better be present at work."

Hasana also noted;

'Time off. Oh our manager said the management does not want to hear us taking time off. I even heard of recent the government does not want us taking sick note or time off. In fact since I started working here over 10 years ago I have never taken time off or taken sick note. No never….. …..It is not even recognised here anyway it is regarded as being lazy in this hospital. Since I am not a lazy person I do not take time off work I deal with the work and get through it''

Eniola, one of the MWAs working in the same hospital as Ifeoluwaposi, gave a very painful account of the issues around taking time off. She said;

"Here (hospital) you cannot be sick not to talk of getting a time off. If not, you (MWAs) will be told you (MWAs) are lazy. Even with the miscarriage, I had to come to work on Friday. I had Wednesday and Thursday off that was why I didn't come to work. That Friday at work I fainted and started bleeding."

The MWAs' fear of losing their job and also being labelled 'lazy' by senior staff was a factor that explained why it was not possible to take time off work. The MWAs cited other experiences and the responses from senior staff, as reasons why the idea of 'taking time off' was totally unacceptable across the three hospitals.

Although, there were no official records of staff turnover, it was inferred from the figures collected by the researcher on the length of time (as long as 10 years) the MWAs were employed in the hospitals that staff turnover was low. This low turnover can be attributed to the fact that MWAs tend to stay longer

in the job despite their experience of continuous exposure to occupational stress and the inability to take time off work when required. In part this may be explained by the issue of job insecurity in Nigeria which was an important factor as the MWAs feared they might not get another job if they decided to leave their current role and this may account for low staff turnover among the MWAs.

5.3.3: Comment and conversations on stress with other colleagues

Following on from the individual constructions of the meaning of stress, MWAs also described drawing on the comments and conversations with other colleagues, including some senior staff. This further reinforced their definition and perceptions of occupational stress.

Due to the nature of their work, often working on their own, many MWAs described sharing their work experiences and passing comments on how stressed they were with other MWAs. One of the MWAs, Monisola, described a situation where a senior member of staff actually commented on how stressed she was and advised her to get some rest. Although this only happens when she works with certain midwives. Monisola stated;

> "There are nice people (midwives) in fact sometimes they (midwives) too they pity us (MWAs) and tell us to go and rest"

Most of the MWAs described noticing stress in their colleagues and were able to recognise it because they shared very similar experiences, including feeling tired and unwell. For instance, Camiye noted;

> ".... usually we (MWAs) all are stressed. When you see your colleague that is doing the same thing you will know. Except some (attendants) that work in wards that are not as busy as the maternity ward"

This excerpt from Camiye highlights further how busy the maternity ward was compared to other departments within the hospitals. This comment was supported by other MWAs, who indicated that attendants in other departments did not work as much compared to those on the maternity ward.

Some of the MWAs remarked on colleagues' expressions of stress. An example is quoted from Jerisanu, who noted;

> "In fact at this work we know ourselves. When I see that my colleague's face is looking hard I just greet and pass by because I know she can snap at me if I say something she does not like. Seeing her like that I know there is nothing else wrong with her than she is stressed because of the work she has been doing since morning so she will be cranky."

Eniola described knowing her colleagues (MWAs) were stressed from their conversations. She reflected;

> "Sometimes without asking she (colleague) can say ahhh I am tired the day has been very busy. That way I already know that they are stressed"

Other MWAs described discussing work issues, either when they met each other in the corridor on their way to different duty locations or during handovers when they were sitting in the store room/ the attendant's base. For instance, Fifoluwa reported;

> "Some will have a serious frown and when you greet them (colleague) it will just be a funny response I get. That just tells me she is stressed. It is quite easy to tell because I also face the same thing. There are situations … the next thing I can hear is 'oh it is so busy today I am already tired' without asking. This is what we do and everyone is totally stressed at this job."

Some MWAs also described talking about work stress with other ward attendants from different wards. The MWAs made an effort to find some time to share their issues at work and experiences of stress, although it was not always possible. This was also attributed to how they dealt with stress (see coping mechanism and support 5.6).

5.3.4 Employer's Policy on occupational stress.

The MWAs described different situations where their employer did not always show any concern for their well-being at work. Bolutife remarked;

“They (employer) do not care at all about how you (MWA) are feeling”.

Jerisanu also expressed concern about the lack of care MWAs experienced from her employers/management compared to how senior members of staff were treated. She reported

> “They (employer) do not care about us (MWAs) at all. They (employer) protect the nurses and the doctors but not the attendants (MWAs)”.

Labake noted:

> “..but our direct *** does not understand but I know they do but because they are senior staff they do not care at all”

It was apparent from the discussions that across the different hospitals there was no policy regarding occupational stress, sickness/absence or shift patterns worked. Hence, work organisation for MWAs varied across the three different hospitals, which confirmed the inconsistencies highlighted in the discussion above. Furthermore, the MWAs highlighted the issue of preferential treatment given to senior staff, specifically the nurses/midwives and doctors. Jerisanu recalled a situation when the staff in the hospital embarked on industrial strike action because of unfavourable working conditions. However, the MWAs were not allowed to join the strike and were told by some senior staff to carry on working but not to wear their uniforms to make it less obvious they were not part of the strike action. Yet, the MWAs were left out of any management resolutions as a result of the strike actions. Jerisanu described;

> “The nurses and midwives know how they fight for themselves. If they (midwives) do not like anything that is happening, they will strike….. During the strike they (management) told us (MWA) not to wear our uniform to work so people will not know we are working during the strike. Imagine, yet they will not help us.”

Kitan added:

> “Even when they (management) know you (MWA) are pregnant it does not reduce the work load at all. Here they do not care at all”.

Likewise Temitayo said:

> "When I am off I will try to rest, they (management) do not care about us especially we attendants… how long will one (Temitayo) continue like this and our *** do not care. If not all the complaint we have been making they will have done something to reduce the work but.."

In summary this section has provided rich descriptions of the MWAs' experiences of occupational stress at work. The word 'stress' formed part of the MWAs' daily vocabulary within the maternity setting. The ways MWAs described stress included saying how they felt due to the working conditions within the maternity settings. Many of the MWAs attributed tiredness, exhaustion and weakness to stress and used this language to describe the negative experience of occupational stress. The next section provides the findings on the second area explored, namely 'the sources of occupational stress' among MWAs.

5.4 Sources of occupational stress among Maternity Ward Attendants.

It was important to explore the causes of stress to gain an in-depth understanding of the different demands MWAs were exposed to within the maternity settings and across the hospitals. This assisted in determining whether MWAs from different hospitals were exposed to similar types of work stressors. In addition, to establish whether the MWAs generally had similar perceptions on the causes of stress unique to individual hospitals or the role as a whole.

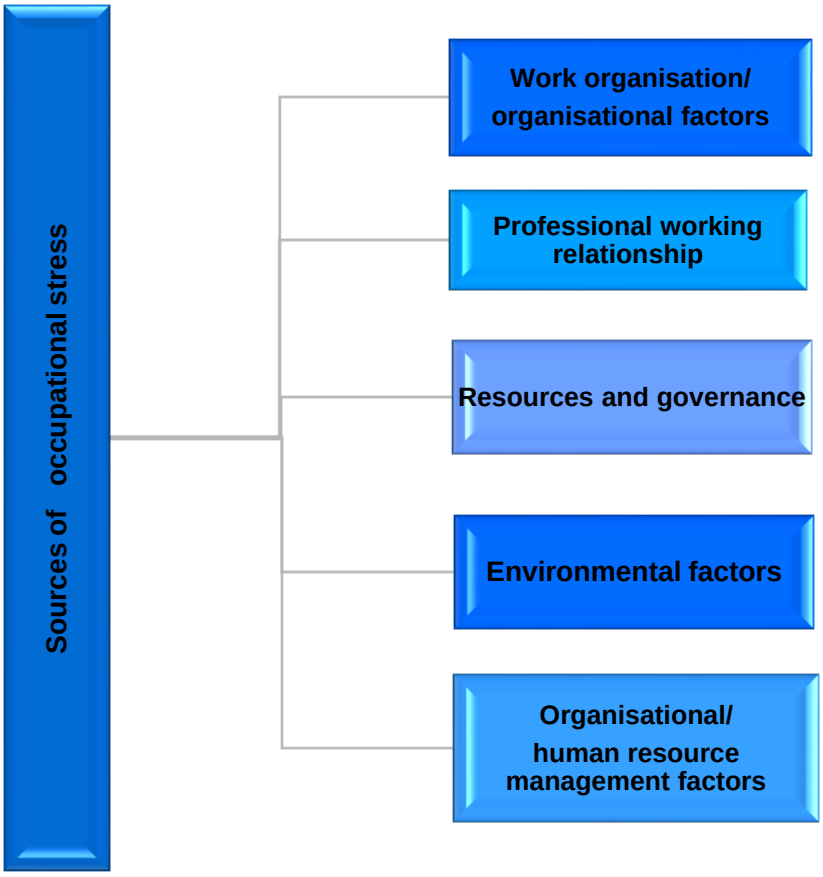
This section provides detailed analysis of the sources of occupational stress among MWAs. Five themes emerged while exploring this area (see diagram 6). These themes have underpinning sub-themes identified following an in-depth analysis of the descriptions provided by the MWAs of the causes of occupational stress. The causes (sub-themes) included: inadequate equipment, poor relationships with senior staff, heavy workloads and constant walking back and forth whilst managing the discharged patients. However, some of the MWAs started by describing the stressful nature of their job. This

led to a further probe in relation to the particular aspects of the MWAs' job that were deemed more stressful than the others, in order to gain an in-depth understanding of the different categories of stressors. In exploring these further, there were similarities in the causes of stress identified among MWAs in the three different hospitals. There were also some differences in the areas of work identified as the most stressful aspects of their job. For instance, Hasana confirmed;

> **"**It is the lifting and pushing that we do, it is too stressful. Apart from the other work that I do on the ward, these ones are just too much. When I am wheeling patients from one floor to the other, it is with so much concentration because I do not want to fall with the patient going down the slope or pushing the patient up the slope it is with all my strength and body".

The majority of the MWAs identified patient discharge duties as one of the most stressful aspects of their job. This involved the MWA with or without a member of the patient's family, going to at least five different departments, including the pharmacy, to confirm there was no outstanding bill payments.

Diagram 6: Themes that emerged from exploring the sources occupational stress among MWAs



Below are some comments taken from the interviews with the MWAs describing the stressful nature of work on the maternity ward. Bolutife said; "The whole work is stressful".

The MWAs also described the continuous pacing about the hospital to call the doctor or to run quick errands, especially during an emergency situation, as another stressful aspect of their job. For instance, Camiye stated;

> "...it is the up and down. Go here, go there, go and call that person, go call the doctor……. it is too much"

The MWAs also explained that they frequently cover different wards in a single shift due to staff shortages or annual leave and this increased their workload. The MWAs also described duplication and repetition of work where they had

to repeat the same task within a short time on another ward floor while covering a shift. For instance, Rininuola said;

> ‘’ahh the one that stresses us most is that when we (MWAs) mop, we will mop the third (floor) and mop the fourth (floor) too, then we will go and wash the toilet and washing that toilet too use ahhhh energy and all the walls too we have to wash it.’’

5.4.1 Work organisation/organisational factors

Work organisation/organisational factors arise due to role, job and physical factors operating within an organisation that causes occupational stress (Michie 2002). Most of the MWAs from the three hospitals identified similar organisational factors/stressors and the sub themes included shift patterns, long working hours, work overload, role expansion, role expectation, poor staffing level and staff shortages. These were the most stressful aspects of working in the maternity setting identified above. The causes are detailed below.

A major cause of stress for the MWAs was working irregular schedules/shift patterns, and the long working hours. Despite working long hours, specifically on a night shift which lasts for 16 hours (1600 to 0800 hours), the MWAs generally tended to work at least an hour extra after their shift ended due to the workload and not completing tasks. The irregular shift patterns caused a series of problems for the MWAs, which included getting home exceptionally late, and this impacted on family relations and limited the time available to rest. For instance, Olaoluwa said;

> “If we (MWAs) do night shifts too, 11:00 am we can still be here and have not gone home.....”

Temitayo also stated;

> “Imagine after all the work, if I do a night shift I will not finish until 8 in the morning. You see that 8am might be when I want to start something I was meant to do before because it was busy all night. Now when I finish around 9 or 10am and I am just going home...”

A few of the MWAs chose to share their rota (roster) for the week with the researcher. This confirmed the irregular shift pattern, having to work night shifts (16:00hrs to 8:00am) and then return the next day for a morning shift (8:00hrs to 16:00hrs). For instance, Ifeoluwaposi remarked;

> "…imagine working this kind of roster (rota), I cannot work effectively it is not possible."

This statement highlighted the effect working irregular shift patterns and the effects inadequate time off work had on the quality of MWAs' work within the maternity setting. Ifeoluwaposi described other factors that contributed to her working beyond the end of her shift and explained;

> "....I might not leave work when I finish my shift. I sometimes stay hours after especially when I go to collect blood outside the hospital like from **** hospital. It is at that time when I get back that I can now go home, it is not good. All these makes the work more stressful."

Other MWAs emphasised not having enough time off work scheduled into their rota. This issue was often mentioned when discussing shift patterns and long working hours. For instance, Fifoluwa expressed dissatisfaction at the tight rota schedule due to staff (MWAs) shortage within the maternity settings. She expressed;

> ".... for the work we attendants (MWAs) do and they (management) did not allocate the time off work well because we are not enough (short staffed) we do not have plenty time off work on our rota"

A combination of the irregular shift patterns, long working hours, inadequate time off work scheduled in the rota contributed to the MWAs feeling exhausted, sleep deprived, not having enough time to rest or recover from work, which often led to stress.

The MWAs each spoke of their individual experiences of role stress specifically in relation to work overload. Work overload is described as a situation where an individual perceives they are working beyond their capability with limited

resources available to complete the tasks within the allocated time (Steptoe-Warren 2013). In this case the MWAs felt they always had too many tasks to perform. The MWAs across the three hospitals consistently described work overload as the major cause of stress due to the constantly increasing workload and responsibilities that they were expected to undertake. The MWAs mentioned work overload more than any other work stressor.

The MWAs noted the difficulty they frequently experienced when they were trying to complete a task properly and having to deal with constant interruptions from senior staff, as Kitan observed;

‘’The work is too much for one person’’.

This was reiterated by the majority of MWAs who described similar situations. For instance, Dayo remarked;

“The work on attendants (MWAs) alone is too much”.

Specifically, most of the MWAs identified increasing work overload as one of the major causes of stress. Camiye commented;

‘’There is just too much to do honestly and it is just one person on this ward”.

Gbemisola also said;

> “...when I have to do all the work on the ward and then add going around to the laboratory and doing clearance (patient discharge duties). So it is stressful combining that to the work and managing all together… It is not easy. It is too much work on one person. Yet they (management) will not get more staff but keep adding to it”

Several of the common issues that contributed to the increased work overload were discussed and included the continuous reduction in the number of staff (MWAs). Many of the MWAs in one of the hospital sites also identified the unequal delegation of workload/responsibilities amongst the different departments as another reason for work overload. The inequality was often due to an improper or unequal delegation of work by the departmental managers. This can be attributed to the inconsistencies in work organisation and in most situations, the MWA role just keeps evolving, as discussed earlier.

Bolutife described carrying out tasks which she believed could be done by another member of staff within other departments and said;

> ”I will go for the oxygen tank, when I challenged this that the store attendants should carry the gas (oxygen gas tank)... the nurses refused”.

The MWAs suggested re-delegating the task to the appropriate department, however the management considered these duties to be part of the MWAs' duties. Thus, MWAs described attempts to meet excessive work overloads as 'beyond their ability' in most cases. One of the workload issues was not having enough time to accomplish a task effectively before having to do something else. Furthermore, to manage the work overload many of the MWAs frequently worked longer, unpaid hours which also contributed to their experience of stress. This was strongly linked to long working hours which were discussed earlier.

The MWAs discussed how their role was expanded with tasks that were originally not part of their workload. However, due to the lack of an official job description that outlined their specific duties, the hospital management were perceived to be constantly expanding the MWA role without informing them. Consequently, MWAs across the three hospitals identified the different tasks they did which were initially not part of their duties, including domestic duties.

Olaoluwa explained why there was a constant addition of duties to her role. She said

> “….because previously they (management) employed those that bring food and come back to collect the plates, but now they (management) have added that task to our role. It is part of our duty that we will go and collect report (midwife's report book) ….”

The MWAs explained that in the past, the hospital management employed other staff (attendants) to work in different departments including the kitchen, or as cleaners. However, recently the number of staff employed had reduced leading to the role of the MWAs being expanded to accommodate these

additional duties. Another reason for role expansion was that a significant number of MWAs had retired in recent years. This was mainly because older women were initially recruited as MWAs when the role was first introduced. Due to the unreliable document management system in Nigeria, it could not be ascertained exactly when the role was introduced into the maternity service. However, it was inferred from reports that the role was introduced in the early 1980s to support midwives and mothers (Oyetunde and Ayeni 2014). However, the hospital management did not recruit adequate staff (attendants/MWAs) to fill the vacuum left by the retired MWAs. For instance, Pamilerin confirmed;

> ‘’there is no replacement for them (retired MWAs). So that their own work is now in our own (MWAs) hands. So like now ideally I should only be doing one ward if we (MWAs) had much hands (MWAs) on our ward’’.

Another reason for the continuous MWAs’ role expansion was the inconsistencies in working practices between the hospitals governed under the HSC. For example, some of the MWAs at one hospital site had a dual role both as a MWA and a cleaner. Whilst another hospital, had cleaners who worked outside the hospital buildings cleaning the surrounding compound (the outside vicinity of the hospital). However, some MWAs at another site had to work on a rota basis with other attendants in different department to clean the compound. As, Bolutife remarked;

> “.... here there are no cleaners so, we do the cleaners and MWAs work together. It is not fair.”

The constant role expansion had occurred without proper consideration and lack of consultation from the hospital management. This was another case of roles evolving within the maternity settings and a lack of role clarity for the MWAs.

Role expansion was not limited to duties within the maternity setting but extended to running personal errands for the nurses and doctors and this left the MWAs with competing demands. In such situations, the MWAs were

unable to say 'NO' or refuse to undertake personal errands due to fear of being reported for insubordination to the management by the senior member of staff. Despite their work overload, MWAs described running personal errands for senior staff as well as the pregnant or new mothers, for instance outside visiting hours or for women who sometimes did not have a family member to support them in the hospital. Jerisanu remarked;

> **"**I do go and buy food for the nurses and doctors. Even the patients that do not have any relative to send to help them buy food, I will go for them too."

Camiye also said;

> "The times maybe they (nurses or doctors) did not bring food from home they (nurses or doctors) will send me to buy from outside the hospital. In other situations, if they want to buy something from any shop outside or something they will also send me ".

Eniola described this as an additional work which was not included in her duties but she still had to create time to run personal errands to avoid being reported or labelled lazy by the senior staff. She said;

"....it is extra work. That is something that is not our duty."

However, despite the competing demands from senior staff the MWAs did not have a problem with supporting the patients (pregnant women/new mothers) and commented that the new mothers were especially grateful to them for running errands. In addition, the MWAs noted that they often got commended for their hard work by the patients' relatives.

The MWAs stated that senior staff and management had high work expectations of MWAs. In particular, two MWAs noted this meant they had to backfill for staff shortage. The MWAs explained they felt overwhelmed by the management's high expectations and this made it harder to cope with occupational stress. Pamilerin described her experience of work duplication and high performance expectations, especially when covering other wards. She stated;

> "…after I have done that ward and where there is any staff absence..… I will come downstairs again to work … and they (management) expect me to do the same thing again as I did upstairs. Is it easy? I will also sweep, mop and empty the bins.."

The issue of the high performance expectation was exacerbated by a lack of official policy documents or job description detailing what was expected of the MWAs' role. Hence, the MWAs were increasingly exposed to multiple demands from senior staff. The MWAs felt that the demands placed on them were unrealistic. This finding was applicable to all three hospitals as the MWAs described different experiences. For instance, Yejide observed;

> "..and they (management) expect you (MWAs) that were there is lapses in another ward you (MWAs) should still cover it."

The issue of staff shortages and poor staffing (MWAs) levels on the maternity ward was mentioned several times by the MWAs in the three hospitals. Staff shortages were regarded as a major source of occupational stress and a reason for other stressors including work overload. The MWAs noted that poor staffing on the maternity ward caused stressful consequences and resulted in working additional hours without pay, loss of family time, physical and mental strain due to extra workload. The reason for staff shortages/poor staffing levels was often linked to the management's ongoing reluctance to recruit more staff into the role. For instance; Labake reported

> **"**ahhh they (management) too know that it is because we (MWA) are short staffed that is why we are feeling all these things. You know since they are aware we are stressed at this job, we do not have to keep reminding them (management) again for them to do something about it."

Wonuola also noted;

> "we (MWAs) do not have enough MWAs especially on this maternity ward we are not enough, so the work is plenty for just me".

The impact of this issue was described by Monisola. She said;

> "..at least you (the researcher) can see how I have been stressed, only one person doing all the work and undergoing stress.."

This was also supported by Semilanu, another MWA, who outlined the effect of staff shortages on her workload and the pace of work. She commented;

> "ahhh well it is our work but the thing is that like now see I am the only one on shifting (shift) now and I will have to be one doing all the work even when we have emergency…...as I am cleaning blood on the floor, they (nurses/doctors) can call me that they need something else somewhere so I will have to clean that and rush again to go and do what I am needed for".

Poor staffing levels also impacted on the MWAs' working hours and the time they could end their shift. Adunoluwa said;

> "..when I got back (from collecting blood from another hospital's laboratory) I had like 30minutes to the end of my shift but I still had my work to do since I am the only one on the ward…"

Such extended working hours had a negative impact on family life because the MWAs often left work after their shift had ended, arrived home late, had limited time to spend with their family and were too exhausted to have meaningful conversations. Another impact of staff shortages is also strongly linked to the work overload endured by the MWAs, as stated earlier. Eniola confirmed;

> "Especially this maternity ward, it is too busy and there are not enough MWAs to do the work."

5.4.2 Professional working relationship:

Direct quotes from the MWAs illustrate that professional working relationships with other senior staff within the maternity setting was another factor that caused occupational stress. Generally, most MWAs from the three hospitals perceived themselves as 'mere MWAs' with a low level of education and were

regarded similarly by senior staff. Although they were junior staff, the MWAs still felt they were treated unfairly in most situations. For example, quotes again illustrate that there was a lack of MWAs' input and consultation in decision-making, a lack of respect and recognition by senior staff, not being part of the team, senior staff exploitation, poor management of MWAs and lack of support from senior staff. Within this theme there are six sub themes which will be discussed below.

The lack of input from MWAs into decisions that pertained to their work appeared to be an important cause of occupational stress. Inadequate consultation with the MWAs on what works best or practises that suit their role or impacted upon them accounted for many of the comments made. This was consistent across the three hospitals and the MWAs expressed resentment at the lack of opportunity to contribute to important decisions which had the potential to have either a positive or mostly negative effect on their work experience and health and well-being. A few of the MWAs noted that the management occasionally said they would look at their complaints, but this had not happened. In such cases, the MWAs believed that it was not a genuine effort to respond to or even recognise their complaints as the management continued to ignore any feedback from them. For instance, the MWAs described situations where their shift had been swopped around either from working both shifts (morning and night) to permanent morning shifts without proper consultation. Bolutife said;

> **"...**but knowing them (senior staff and management), they usually just change the roster (rota) without even telling you...".

Jerisanu also noted;

> "…The thing about this work is that if it is my own work that I do without all the extra work that is always attached to it, even without informing us they (management) will just call you and say now this is what you will do also. I will not mind at least I will know that is my work and I will be able to manage it. "

As highlighted with role expansion, the MWAs believed the management did not regard them as important enough to seek their opinion in decisions

pertaining to their duties or consider the impact it would have on their well-being.

The MWAs believed that the decisions made by the management as illustrated above were influenced by corporate and financial considerations with little thought about the MWAs or their health and well-being needs. As a consequence of, their limited inclusion in the decision-making process, MWAs reported feeling powerless, helpless and having a lack of control over their role. Kitan contented;

> "I did not use to collect blood before it was when there was no staff again that they (management) just said MWAs should be collecting blood too, without even asking us if we can do it or add it to our work. That is how they treat junior workers here as if we too are not human beings"

Gbemisola also confirmed;

> "….., the work itself is too much, they should stop adding work (tasks) to the work without even asking. They (management) can just summon or send letter that we are now to start cleaning another place."

This issue of lack of input in decision-making is linked to lack of respect discussed below.

Some of the MWAs identified that not being recognised or treated with respect by the senior staff caused them stress. This contributed to the MWAs negative experience and occupational stress within the maternity settings. This had led to some MWAs' feeling low self-esteem. For instance, Fifoluwa indicated;

> "Here we MWAs are not human we are not even regarded as staff. They treat us like servants that are here to serve."

Gbemisola also said; "our employer does not even recognise us as staff"

However, some of the MWAs felt that despite their low level of education and the lack of respect shown to them, they considered themselves as

fundamental to the maternity service. One of the MWA used the word 'pillar' to describe how significant the role was within the maternity ward. Adunoluwa said;

> "Now imagine we attendants are the pillars of the hospitals..... Yet if we (MWAs) all leave the job the work will be left lying fallow because neither the nurses nor doctors can stand what we do. They do not care at all about how you (MWAs) are feeling."

Other MWAs described covering a shift in the absence of a colleague but were still not being recognised as a team member despite working beyond their capacity to cover gaps within the maternity ward staffing.

Furthermore, the MWAs indicated that a sense of inequality existed between the senior staff and the MWAs. Although the MWAs acted respectfully towards the senior staff, they indicated that senior staff were not expected to reciprocate because MWAs were junior staff. The MWAs felt the reason for this was that the senior staff, including the doctors, sometimes behaved in a superior manner and tended to misuse the authority related to their senior positions. This was illustrated in the quotes below. For instance, Fifoluwa indicated;

> ''Some of them (doctors) are even so rude that they talk to you anyhow like I am not human''.

The MWAs often described feeing undervalued. Several different experiences were described by the MWAs where senior staff, co-ordinators and members of the management team had silenced them from speaking about their work experience or making a complaint. Labake stated;

> **"....** they (management/senior staff) do not want to listen to anything at all or hear that you (MWAs) are stressed …."

Adunoluwa also said;

> "Even when you (MWAs) tell your….. about the stress, I hear responses like 'you are not doing enough that is why you have time to talk about it'."

The MWAs also described the negative responses from the senior staff when they complained about their work experiences within the maternity settings. Eniola remarked;

> "If we (MWAs) complain, they (management) will tell you if you (MWAs) work really hard you should always get home and use paracetamol (pain killers) then you will know that you have worked. Is that fair?"

The MWAs discussed one form of disrespect was when management made a conscious effort to remind them of their uneducated status, taking advantage of this to further exploit the MWAs. This was exacerbated by the lack of support or a MWA representative to consult with the management. Bolutife indicated;

> "As they (Management) will always say we (MWAs) are just mere junior workers just attendants with no education. So I know that is why they can do what they (Management) please and no one to fight for us (MWAs)."

The MWA experienced verbal abuse from senior staff, including the midwives and doctors, if they complained about either a change in rota or extra workload. This was highlighted by various examples from MWAs in the three hospitals. For instance, Gbemisola said;

> **"**Here when you (MWA) complain too much ahhh, the *** can just abuse you there and then..."

The MWAs also described situations when they felt insulted or verbally abused for not running personal errands immediately or if they complained about being stressed. Kitan confirmed;

> "How can only one person be doing all this work and yet when I complain or raise it that they (management) should get more people I will be insulted to an extent I will regret raising it."

Hasana also noted;

> "in fact**** will insult you (MWAs) when you complain. ***** will verbally abuse the living day out of you (MWA), telling you off that

> ‘it is because we (MWA) are not educated that is why we are talking like’.....”

The MWAs also described experiencing threatening comments from the senior staff that included being accused of insubordination, as noted earlier. The senior staff believed the MWAs were there to undertake any task, including running personal errands and the MWAs felt obligated to do this irrespective of the work they needed to do. This threat of insubordination or being labelled as rude was mostly experienced when the MWAs refused to do personal errands due to the limited time available to finish the duties they were employed for within the hospital. Some of the MWAs also made comments about feeling threatened. For instance, Adunoluwa indicated;

> **“**…I run personal errands for nurses and sometimes doctors. I cannot say no because it can be used against me (MWAs) in a way unexpected. Or we (MWAs) are reported as rude and lazy for not attending to an errand”.

Olaoluwa also stated;

> “.....because we (MWAs) are under them (senior staff) and if we (MWAs) do something ahhh they will say we are rude to them so...”

As highlighted in the quotes, MWAs’ felt helpless in relation to the demands placed upon them by the senior staff and that they had no choice because they were considered to be junior staff and had no voice within the maternity settings.

Furthermore, the MWAs described how they were labelled lazy either for refusing to run personal errands or complaining about work. The MWAs’ perceived that taking time off due to work stress was seen by the senior staff or management as an excuse not to come to work and as being ‘lazy’. The thought of taking time off due to stress and fear of being labelled lazy had increased the tension between senior staff and MWA’s. Senior staff’s behaviour was perceived by MWAs to contribute to their experience of occupational stress. Camiye expressed;

> **"**If you (MWAs) complain here they (management) will see you as being lazy and they (management) do not even give sick note without a doctor seeing you and you cannot tell them (management) here it is stress ahhh you have found another job then."

Eniola also stated;

> "To them (management) you should not be taking time off. You are definitely lazy that is why you are taking time off or you have gotten another job somewhere else".

The MWAs described their experience of a poor working relationship with the senior staff, including the midwives. In most cases, it was followed by other comments, including a lack of recognition from management or was mentioned in responses to other questions. Adunoluwa said;

> **"...** some of them (midwives) will not even want to hear you talk at all. So it is not all of them (midwives) that are nice that I can talk to".

Fifoluwa also stated;

> "ahhh madam, madam (…) is not interested to hear all that. That is not her business. Even if you (MWA) are dying like this she is not bothered. In fact, once you begin to say anything that is not about work and it sounds to her like you are complaining about work even if it is public she will shout at you and embarrass you. Even if it is in the presence of patients"

These quotes illustrate the lack of cooperation and poor communication between the senior staff and the MWAs. Hence, as a consequence, the MWAs felt they could not approach the senior staff to complain or explain they were stressed for fear of being verbally abused. Thus, these reactions led to the MWAs feeling unsupported by senior members of staff or management. The MWAs identified that poor communication was a potential cause of the poor

working relationships or the foundation of their negative experience when working with senior staff and management within the maternity setting.
Olaoluwa said;

> "I will also have to go back to pick it (midwife's report book) up meanwhile we (MWAs) do not know what is written in it (nurse's report). Then if they (midwife) want to disturb us they (midwife) will be sending us (MWAs) about, up and down that they (midwife) didn't write this and that in it we should take it back and ask them what they wrote. We (MWAs) will be going back and forth and we are not the one that wrote the report so all that too is part of it"

The MWAs' experience of poor working relationships with senior staff was common across the three hospitals within this study. The MWAs also described situations where they felt anxious when they heard the approaching footsteps of one of the senior managers. They often described these situations like a 'god' approaching because they could be scolded for sitting and not keeping busy with work, even though they were on break. The MWAs often believed their low status and level of education contributed to the poor working relationships and felt belittled by the senior staff and management.

The MWAs were employed within the maternity settings to support the midwives in providing quality care to the mums and babies. However, there was a lack of adequate support for the MWAs to help them cope with the high demands of their role. The MWAs noted that the lack of support from senior members of staff was among the significant stressors within the maternity setting. The MWAs across the three hospital sites described their different experiences of lack of support. Further exploration also revealed that the MWAs did not receive adequate support from the management compared to other senior staff (midwives). This experience made the MWAs feel neglected and undervalued, as stated earlier. For instance, Pamilerin stated**;**

> **"..**Just imagine they (co-ordinator) will say we (MWAs) should work like this and work like that. We will say this work is much ahh that something like this is wrong with us (MWAs). They will insist that we (MWAs) should withstand whatever is wrong with us ohh.

> At least you (researcher) can see they (management) are aware we are short staffed".

It is noteworthy that Pamilerin referred to managers as co-ordinators. Camiye supported this and said;

> "There is really no type of support from our employer. There is absolutely nothing at all from them.....Even to give the right things we (MWAs) need at work like gloves and boots they (employer) will say there is none, no money to buy more".

Fifoluwa confirmed;

> "I cannot even complain because if you complain too much what I will hear is 'you can resign and go'. Imagine."

Bolutife added;

> "Even our **** that are to help fight for better working equipment are not helping they (management) will just get what nurses and doctors need and that is it."

5.4.3 Resources and governance

In addition to the factors previously mentioned, MWAs also remarked that resources and governance were problematic. This was due to inadequate resources, a shortage of resources, a lack of allocated meal breaks and control over shift patterns. These formed sub-themes which were common to the majority of MWAs from all the three hospitals and are discussed below.

The issue of inadequate equipment resonated among the MWAs from the three hospitals and they described different instances when they had to deal with inadequate equipment in the maternity setting, including broken stretchers. This increased the effect of chronic stress and occupational fatigue experienced by the MWAs because they felt the inadequate equipment made it physically harder and it took longer to accomplish a task. The MWAs across the three hospitals identified this as a primary barrier to not carrying out their

role effectively and to the appropriate standard required by the hospital management. For instance, in relation to having sparkling clean bathrooms the MWAs listed an array of equipment and resources that were inadequate, including floor cleaning chemicals, cloths, antibacterial/antiseptic washing up liquid, trolley bins and inadequate cleaning equipment. These resource shortages were common to the three hospitals. For instance, Bolutife said;

> "Even the stretcher we use is not very good. We manage it."

The MWAs mainly from two hospitals described transporting mothers and heavy bins up the slopping corridors, using broken stretchers or wheel chairs. This often required the MWAs to support the stretcher with their body weight to avoid losing control, resulting in it rolling against them or requiring extra effort to push it up the slope. It was apparent that this caused significant physical strain to the MWAs. For instance, Hasana indicated;

> ''..with my chest I will be supporting the stretcher or wheel chair to get it up the slope.... I can finish pushing and be feeling pain in my chest right through to my back.''

In addition, some of the MWAs described suffering severe injuries while working with inadequate equipment. However, such injuries were compounded due to the lack of rest and inability to take time off work to heal. For instance, Jerisanu indicated;

> "…. now this (injured leg) happened here when I was cleaning the window I fell off the platform I climbed on… I am still working and adding to the pain when I cannot rest the leg properly."

Labake also confirmed;

> "...the equipment we use is not adequate….it is not sufficient at all for us to work with. Our work tools are not enough. It is not enough at all, at all..."

The MWAs highlighted the lack of proper logistics or procurement procedures as the main reason for the shortage of resources. One of the MWAs described a situation when she had to collect the maternity ward's supplies for the month

and was given only a few days' worth instead. She noted this was the usual practice within the maternity settings and was often advised by the store clerk to better manage the supplies for the month. The MWA in question showed the researcher a bottle of 1.5 litres of cleaning bleach which she and her colleagues used to wash the toilets for the month. She stated how difficult it was to make this limited volume of cleaning fluid last a full month and ensure the maternity ward was clean. It was apparent the hospital management had high expectations of the MWAs on how the wards should be maintained, yet supplied limited resources to accomplish the task to the required standard.

Furthermore, the issue of poor equipment extends beyond the MWAs working tools to having the right personal protective equipment (PPE). The MWAs frequently highlighted that they were not well protected at work compared to the nurses/midwives and doctors, despite working in the same maternity setting. For instance, Monisola said;

> "…we (MWAs) deal with more blood. See the doctors wear hats and also they (doctors) cover up completely but we MWAs do not wear anything except gloves that reaches the wrist and we carry on working".

These instances indicate how the MWAs had to manage with limited resources within the maternity settings but still had to meet the management's expectations of their role and responsibilities. These were challenging and difficult for the MWAs, who also had to deal with protecting themselves from infections within the maternity wards.

The MWAs from the three hospitals felt they lacked control over their work schedule and described not having a meal break or time for breaks during their shifts either morning or night. For instance, Wonuola noted;

"There is no break time oh…"

This was attributed to poor management organisation and lack of policies mandating work/meal breaks during every shift, despite working long hours. The MWAs also attributed the lack of meals breaks to other reasons, including their work overload, the lack of control over time and staff shortages. The staff shortages/ poor staffing levels on the maternity ward made it exceptionally difficult for MWAs to have meal breaks during a shift as there were no other

staff available to cover their absence. The impact of this was evident in the MWAs descriptions when they felt tired and weak because they had not had any food since they started their shift. This also contributed to the MWAs poor eating habits/unhealthy lifestyles. Olaoluwa noted;

> "…one (MWA) can be hungry and be eating like this, (while in the MWAs' base) they (midwives) will come and call you again. The work that two people should be doing, it is one person that is doing it"

Semilanu remarked;

> "…. we do not have a particular break time like that. It is when I see an opportunity to take a break that I will have it and eat".

In addition, some of the MWAs have had to plead with senior staff to have a break during a busy shift. Adunoluwa stated;

> "In fact I feel dizzy sometimes when I am working; maybe I have not eaten since I started my shift. I will have to beg the midwife to please give me some few minutes to eat..."

The MWAs described how they attempted to create organised break times during their shift, either to eat or rest. However, this was often interrupted by work demands or senior staff calling upon them. Generally, the experience of the MWAs was that often they got asked to return from their breaks because they were not officially recognised by the senior staff. Thus, this situation was worsened by the lack of an official policy or regulation mandating MWAs' breaks within the hospital. Also the fact that only one MWA was on a ward during a shift intensified the issue of lack of meal breaks. For instance, Niniola raised;

> "...yes as stressful as anything. As we (MWAs) are working now (on a night shift) before you can sit down to say you (MWA) want to eat may be around 3am or 4am sometimes 2:30am".

Labake said;

> "...but it is when I just say OK oh let me sit and rest, it might now be that time when I want to rest that they (midwife) will call me and say …this

thing needs to be done. I will have to go and it is not possible to say that I cannot do it".

The MWAs also had the perception that some of the senior staff, specifically the midwives, did not like to see them resting. Instead they felt that they should be working all through the shift. For instance, Temitayo stated,

> ''if I am working with some of these midwives that do not want to see you (MWAs) sit, you (MWAs) must always be working''.

It was apparent that missing meal breaks due to excessive workload contributed to occupational stress for MWAs. Thus, the MWAs found that meal breaks during their shift were at the discretion of senior staff.

5.4.4 Environmental factors:

Another key theme that emerged from exploring the factors that caused MWAs occupational stress was environmental issues. The MWAs described different situations where threats to their health and well-being increased their level of anxiety whilst working within the maternity setting. These environmental factors included exposure to infections on the ward and hazardous working conditions, and a chaotic and unfit work base. These were common to the three hospitals; however, the issue of dangerous working conditions was more prevalent in two hospital sites. MWAs from both hospitals frequently reported suffering from physical injuries, including, in extreme cases, broken legs and more commonly, cuts to the hand.

The issue of a hazardous working environment was another common theme outlined by the MWAs. The MWAs described working in hazardous conditions, including cleaning cracked or broken windows. The MWAs often dealt with used needles thrown carelessly on the bare floor of a labour ward or in the domestic bin rather than being disposed of appropriately**.** This increased the chances of the MWAs getting infected from a needle stick injury. This situation was attributed to the carelessness of the senior staff, including doctors within the hospital. Furthermore, the MWAs' perception was that there were no health and safety measures or guidance enforcing or ensuring best practice in avoiding unnecessary risk to staff's personal safety. This also increased the

pressure on the MWAs to be more cautious in their unsafe working environment. For instance, Pamilerin said;

> **"...**sometimes they (senior staff) are careless. Even the doctors when they use needle they will throw it on the floor. Sometimes they will dispose of it in the domestic bin. So it is only God that is protecting us".

Bolutife also stated

> **"...**see (pointing at the window) it is broken why should this not be fixed ahhh, and you have to clean what is left of it with bare hands, see my finger. I cut my hand trying to clean the other part".

The issue of a hazardous working environment was linked to inadequate and potentially dangerous equipment and the MWAs had suffered various injuries due to such working conditions. The researcher's field notes also captured trip hazards with cables running across the ward floor.

The MWAs worked in an area prone to different infections and diseases. However, there was a limited effort from the management to protect the health and well-being of the staff, specifically the MWAs. The MWAs often described being constantly exposed to infections while working in the maternity ward, due to the lack of adequate PPE and this was a cause for concern. The MWAs explained that when they were initially recruited, the hospital management promised to provide the required injections (immunisation) to protect them against contracting possible infections/diseases. However, they were yet to receive the treatment. The MWAs had attempted on several occasions to follow up on immunisation but failed as the hospital management had not responded to their requests. Thus, the MWAs described taking responsibility to ensure they took extra precautions to protect themselves from any form of infection and limiting the spread to their family members outside work. The thought of infecting their family members with any contracted disease increased the MWAs level of anxiety and stress. For example, Olaoluwa indicated;

> "...I cannot contract any kind of infection I am not to contract and take home so I double it (glove)".

Bolutife added;

> “They should give us anti (vaccines) injections to prevent against some of these infections we are exposed to...”

It was also apparent that the fear of contracting any disease or infection from the maternity ward impacted on the quality of care and support the MWAs gave to the mothers and pregnant women. For instance, a MWA described her experience and level of anxiety during the recent Ebola crisis in Nigeria. Dayo said;

> “.... see during the time of Ebola, when a pregnant woman is rushed into the labour room, the doctors will be wearing elbow length gloves. We (MWAs) didn’t have anything like that. We will just be careful and manage our normal gloves to the wrist or take money from my purse to buy elbow gloves”.

In this circumstance, the perceived lower status of the MWAs’ role disadvantaged them from getting the required protection and support from the senior management. Certainly, within the maternity settings, senior members of staff, including the doctors and midwives/nurses were given preferential treatment while the MWAs felt ignored and left to cater for themselves despite the potential risk.

The MWAs’ work base (rest room) was seen by the researcher as it was the location for most of the interviews conducted in the hospitals. The MWAs seized the opportunity to discuss this room during their interviews. Some of the MWAs specifically mentioned that not having a place to rest or have their meal breaks was a cause of stress. The MWAs described the limited infrastructure and poor condition of their work base compared to the doctor’s room. As a consequence, the MWAs felt they were often exposed to greater risks of contracting malaria from mosquito bites. For instance, Olaoluwa raised; stated

> “… we do not have somewhere that we can have our break. During the night like this …… around 3am the doctors will just enter their own room and switch on the air conditioning, the nurses

> too will enter their own too. This is where we will be that mosquitoes will …. will be biting us …..There is no fan, there is nothing."

The MWAs, specifically in two hospital sites, explained to the researcher that the MWAs' base was a store room (as described earlier) that was cleared by them to create space for a plastic chair and a discarded mattress that could be used as a seat if there was an opportunity for a short break during a shift. This room had a small window facing the corridor, a storage cupboard for cleaning chemicals, no fan and poor lighting. The researcher was also shown the doctors' room. Ironically, opposite this MWAs' base was the well-equipped doctor's room fitted with a television set, air conditioning, a proper bed and a water dispensing unit. Camiye remarked;

> "I have been at work that I got to a point I could not take it anymore, I had to come sit in this our store for some time, if not I could have fainted".

These disparities in facilities contributed to the MWAs feeling of belittlement and discrimination.

5.4.5 Organisational/human resource management factors

These were mainly attributed to financial and reward discrimination within the hospitals. The MWAs believed that they worked longer hours than they were paid for and was a prominent phrase used by the MWAs. Other issues highlighted within this theme included poor remuneration/salary discrimination and lack of reward/incentives, a lack of career opportunities, and discrimination in recruitment.

The MWAs across the three hospitals reported feeling underpaid. The MWAs felt they were paid poor salaries compared to the amount of energy and effort they invested in their work, including the constantly increasing workload. The MWAs identified poor salaries was a concern. This was often linked to inappropriate social status and lack of respect attached to the work of the MWAs within the maternity services. The MWAs described the effect their poor salary had on them and their family life when compared with the volume of

work they did and the amount of time they spent within the maternity settings. Eniola indicated;

> **"**….it is not like the money (salary) is that good. We (MWAs) are just managing it as we (MWAs) get it. Yet I go through all these stress and it is not appreciated. Instead they will be looking for ways to load you more with work".

The MWAs often described being upset and the psychological distress experienced when they thought of their poor salaries and the current economic situation in Nigeria. The MWAs described they felt unable to adequately support their family and live a decent life with their salary. For instance, Camiye said;

> "We do a lot of work in this hospital yet they (Management) pay us so low and see what the economy is saying today and paying us very small money."

The consequence of staff shortages highlighted above had forced MWAs to work longer, unpaid hours. This had contributed to the MWAs low morale, low motivation and feelings their efforts were unrecognised by management. Monisola indicated;

> "...they (management) do not give us anything for working the extra time. It is just to our pocket, ohhh nothing".

Hasana also confirmed;

> "there is nothing like extra pay. 'All is thank you faithful servant'. That is the most you (MWA) get, if you even get thank you"

This was also described as a case of mismatch between pay and the amount of work done for the MWAs. For instance, Pamilerin noted;

> ".....when you (MWA) get paid at the end of the month you will collect 35000 naira, yet you have done the work that is worth 100,000 naira".

One of the MWAs noted there had been several complaints about their poor salaries in an attempt to seek a pay rise. However, they were disregarded by

the senior management, who often reminded them that ward attendants in Western Countries were paid per hour and, they should just carry on working and not complain. This led the MWAs to question the integrity of the salary system within hospitals.

The MWAs also noted the lack of reward or appreciation for the unpaid extra hours. Other MWAs discussed this as another cause of concern, referencing the treatment they experienced as junior staff. Despite going above and beyond, working extra hours for instance, this was not appreciated by the senior staff or management. Adunoluwa said;
"..if you (MWA) even get a thank you; you will be glad."

Adunoluwa also noted that there were issues and irregularities with the annual incentive scheme. She said;

> "…. even during the festive season that other hospitals get Christmas gifts like small packs of rice and mini jerry cans of oil, we do not get anything except very little cups of rice that is not enough to feed a family for a week".

Other MWAs also expressed their dissatisfaction at the inequitable yearly incentives, especially during the festive season. The MWAs described how the senior members of staff were given incentives in different forms, like big bags of rice. However, due to the MWAs' low status they were often left out or given a fraction of any festive season incentive allocation from the government. Other MWAs also highlighted the inconsistencies among different hospitals where MWAs were given a better package of such gifts. This dissatisfaction was mainly experienced in two of the three hospital sites and was linked to the work culture that operated within the different hospitals despite working under the same service commission. Some of the MWAs also noted the lack of benefit of being a hospital staff member. For instance, Eniola remarked;

> "It is not like there are free drugs or free admission as hospital staff "

Camiye also stated;

> "And you know as a staff there should be something you will benefit like free admission when you (MWA) are admitted in

> hospital or you need drugs as a staff of HSC, there should be free drugs and even for family members too."

Monisola indicated;

> "we are not enjoying them (management) here. If we fall sick here they do not give us drugs they (pharmacy staff) will say there is no drug and we buy our drugs with our money"

The issue of a lack of career development opportunities for the MWAs was also noted as causing stress. A couple of the MWAs described their experience of lack of career advancement despite being more qualified than some of their colleagues. Olaoluwa said;

> "…. there is no (advancement opportunity). There is at least…. (process and polices) which are all with them (management). If they (management) want to do it at least they know what to do".

Gbemisola also remarked;

> "In other hospitals I hear they promote some or send them on training but here there is nothing for us".

The MWAs often stated that they did not have the opportunity to progress beyond their current role within the hospital. Some of the MWAs described their current job as an opportunity to avoid being unemployed. However, it was with the hope of moving into a role that at least matched their level of qualification. Despite having higher qualifications, some MWAs' accepted the job of MWA due to the high level of unemployment and difficulty in securing a job in Nigeria. The MWAs recounted being advised by some HSC staff during recruitment to accept the job offer and present lower qualifications to match the current role during the document verification exercise. This was with the promise that in the near future the MWAs would present their higher qualifications to the hospital management for an upgrade to a higher role such as an administrative officer. Due to the fear of losing the job opportunity, employability issues and the dysfunctional labour market in Nigeria, MWAs accepted the situation.

Despite having career progression protocols and the relevant qualifications, the MWAs described a lack of concern from the management to support advancement. Thus, the MWAs often felt stuck in their current role with no opportunity for advancement. Furthermore, the MWAs felt unhappy that they invested so much energy and time into the hospital and yet the management were not making an effort to support their career advancement or progression.

The process of advancement was also perceived to be stressful and complicated by political motives, where non-deserving colleagues were chosen over more qualified candidates. The MWAs described the irregularities and politics that operated when selecting MWAs for training despite some not meeting the required qualifying criteria. These training programs were for MWAs on a particular level to learn certain clinical procedures, including checking patients' blood pressure to build their skills within the maternity setting. Uzomma remarked;

> "...they (recruitment office) now said … that you (Uzomma) have to be on level four…that was when they (management) gave that excuse …. then I said I cannot argue but this person (selected candidate) has not attained level four and they (management) selected her so it was now a situation of politics…."

Despite this training opportunity, one of the MWAs highlighted that there was no advantage for those who attended such training opportunities as they were not promoted or given a pay increment as promised. In addition, the MWA noted that the HSC had also stopped running the training program without giving any reason. Pamilerin stated;

> "...they (HSC) are not sponsoring the training anymore except those (MWA) that might want to go on their own (MWA) will sponsor themselves… But if they come back from the training, they (HSC) might accept them oh you understand, they might accept it (qualification) and upgrade them oh but even the once they trained never got upgraded just that they do not clean anymore and they did not increase their money or their levels".

Another MWA described a colleague's situation who was employed on a temporary basis and despite working in the hospital for seven years was yet

to be confirmed as a permanent staff member. However, another staff member was made permanent just a year after being employed. This highlighted the recruitment irregularities operating within the hospitals. These were linked to a perceived lack of guidelines and official policies on recruitment. For instance, one of the MWAs explained how she was employed to work as a ward attendant despite applying for a different role. She described approaching the HSC armed with her national diploma for an administrative role. Pamilerin added;

> '' I got the job by writing my name on the list held by the man stood on a platform in front of the queue, and he said once your name is written you have gotten the job. That was it. No interview or anything''

Despite having the right qualification at employment, there had been no opportunity to advance into a more desired role and the role upgrade the MWA was promised did not materialise. This confirms the lack of appropriate access to training and developments and impartial appointment and promotion procedures. This had increased the MWAs' experience of stress, resulting in poor emotional outcomes.

In summary, this section presented the emerging themes in relation to the sources of occupational stress for the MWAs. The MWAs identified an array of causes which underpinned the key factors described within this section. The main cause of stress identified by the MWAs was staff shortages, which was the root of other problems within the maternity settings. Other causes include work overload and poor salary. In addition, from the MWAs' perspective, their role had low status within the maternity setting. Arguably this was the reason why the management and senior staff were perceived by the MWAs to constantly exploit, disregard and disrespect the MWAs. There was also a lack of support for career advancement from the hospital management in ensuring the MWAs' employability or progression beyond their current role. Their lack of education was also viewed as one of the greatest barriers to seeking a higher position or career advancement within the maternity setting.

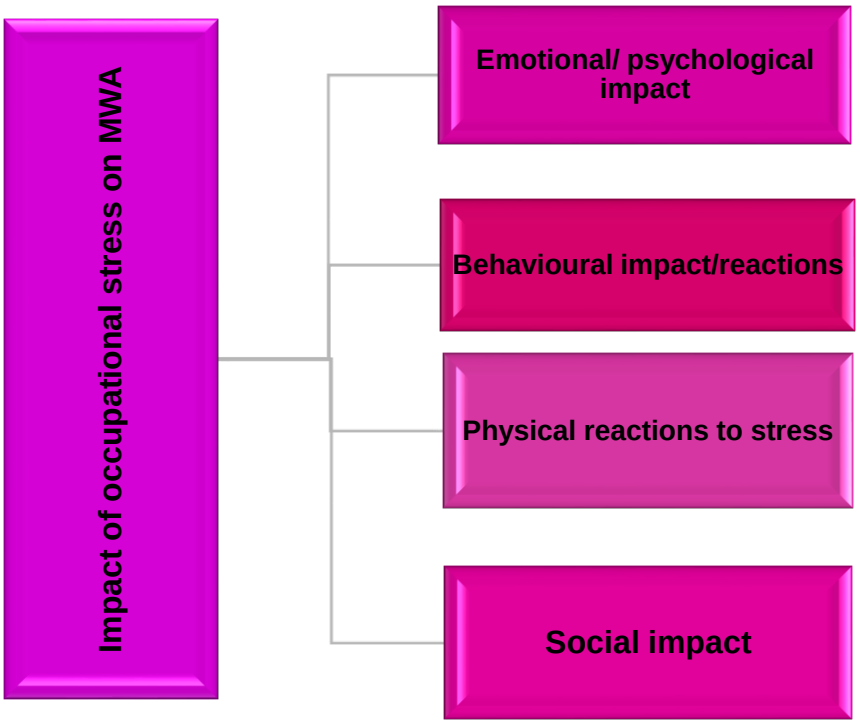
5.5 Impact of occupational stress on Maternity Ward Attendants

The sections above detail the experiences and sources of occupational stress among MWAs. Experiences impacted in different ways on individual MWA's lives including their family relationships. This section presents detailed findings of the impact of stress on MWAs. Following analysis four main themes emerged from exploring the impact of occupational stress on MWAs. These included physical, emotional, social and behavioural impacts (see diagram 7). The discussions with the MWAs revealed that the effects of multiple occupational stressors resulted in different health symptoms, including constant headaches, sleep disorders, general body pain, physical fatigue/weakness, frustration with oneself, feeling helpless, over reliance on medication, reduced family time and anti-social lifestyle. A combination of these stress factors led to negative job outcomes, including job dissatisfaction. In this study, it was considered important to examine the array of symptoms to gain an in-depth understanding of the impact stress had on the MWAs' health and well-being. The health symptoms listed underpinned the sub-themes contained within the four main themes that most aptly described the perception of the effects of stress as experienced by the MWAs. Table 3 below provides a summary of the symptoms experienced by the MWAs as a result of occupational stress. These are not presented in any particular order.

Table 3: Array of symptoms

Emotional/psychological	Behavioural	Physical	Social
Helpless	Cranky and snappy	Back pain	Anti-social life style
Low self-esteem	Over reliance on Medication	Body aches	Withdrawn from family
Sleep disorder	Irritable	Hypertension/high blood pressure	Impact on future career
Frustration	Impatience	Leg pains	
Disheartened	Intolerant	Neck pain	
Anxious		Muscle aches	
Frustrated		Headaches	
De-motivated		Sweating profusely/high temperature	
Feelings of suffering			

Diagram 7: Themes that emerged from exploring the impact of occupational stress on MWAs.



5.5.1 Emotional and psychological impact

The MWAs reported that the negative impact of stress led to various emotional/psychological reactions which they experienced when they were at work and home. The combination and intensity of these negative emotions caused MWAs' excessive worry within the maternity setting. These reactions also impacted on family relationships and rapport with work colleagues. The MWAs often felt overwhelmed with the lack of control they had over their work and this contributed to the different emotional reactions they experienced at work. The MWAs discussed an array of emotional reactions to stress which were similar across the three hospital sites. However, the emotional impact

was described differently using various expressions, such as feelings of suffering, feeling frustrated and helpless, experiencing low self-esteem.

The issue of low self-esteem permeated throughout all the interviews. The MWAs often expressed how they had negative thoughts about themselves when experiencing the factors that causes occupational stress, including poor working conditions and a lack of control over their job. This was also influenced by the MWAs' inability to share their work experiences with the senior staff in the absence of a colleague on the ward. This was because there was only one MWA working with the midwives during a shift (2 to 3 midwives per shift). The only time there was an overlap and more than one MWA on the ward was during the handover period. Although there were other members of staff working on the maternity ward, including security staff at the entrance, the doctors (when they were required) and the maintenance person, the MWAs described there were limited people to talk to on the ward. In such situations, the MWAs had only the midwives they worked with who they often could not share their stress issues with (except if it was a more approachable midwife; see 5.6.3) due to fear of being insulted. This issue of MWAs being insulted by senior staff or management and the lack of appreciation for playing a key role within the maternity setting also contributed to their experience of low self-esteem. Consequently, MWAs described themselves as more domestic than clinical support staff. For instance, Adunoluwa said;
"Cleaners (referring to herself) do not have a say here."

This perception had lowered the self-esteem of some of the MWAs who often felt belittled within the maternity setting. The MMAs attributed this to the absence of a representative or advocate for MWAs within the senior management team. Someone to defend their request for better working conditions, to speak on their behalf and assist them in communicating with the executive leadership, compared to the doctors/midwives. The low level of education also played a role in the MWAs' low self-esteem. The recruitment procedure was inconsistent across the three sites and the general requirement was for MWAs to have at least a West African School Leaving Certificate (WASCE) with four credits, equivalent to four passes in GCSE. However, as

noted, not all the MWAs were recruited using the same procedure and criteria (see section on career development and biographic characteristics).

The perceived unsupportive and unfair treatment from the senior members of staff and management were contributory factors to the MWAs' low self-esteem. The issue of unfair treatment was attributed to management often discriminating against the MWAs because of their low level of education and being considered junior workers within the hospitals. Thus, the MWAs often had the perception that if they were educated (as the doctors and midwives were) they would be more respected and not discriminated within the workplace (see 5.3.4 employer policy on stress). For instance, Temitayo remarked;

> "...it is not their (management) business at all. To them (management) we are just common MWAs that didn't go to school."

The MWAs expressed feeling worthless and unaccepted within the hospital settings due to their educational status. All these factors contributed to the low self-esteem experienced by the MWAs within the maternity setting. Wonuola noted;

> "I will just be thinking for what I can do but because I do not have another job that I can go to I will continue and which school do I want to go at this time or which job can I do now, so I will have to continue here but the stress is plenty in the job. It would have been good if I could do something else but there is nothing I can do especially now that everything is for the educated person so what can someone do?"

Experiencing anxiety as a consequence of stress emerged as a common phenomenon with some the MWAs describing anxious almost on a daily basis when stress at work.

The MWAs also described feeling anxious due to several factors, including exposure to dangerous working conditions. The symptoms of anxiety often

included an over concern for the lack of control or impact of work on their personal life. The MWAs, due to lack of control over time/job, described feeling stuck in their current work situation with no hope of getting a better working life.

The feelings of anxiety were also linked to some MWAs' having difficulty with sleeping, low moods, and poor appetite. The MWAs' feelings of being unsupported within the maternity setting underpinned their negative experiences and led to helplessness. For instance, Adunoluwa said,

> **"...**stressed out every time, that I get home and feel so useless to myself. God should just have mercy really. This work really needs to change. It is just too much for one person."

The MWAs' constantly worried about their poor work environment as this increased the level of anxiety experienced within the maternity setting. The frequency with which the MWA experienced anxiety was almost on a daily basis due to continuous exposure to the same occupational stressors. For instance, Gbemisola noted;

> ''....it is just the thought of oh I am going to that place again, that kind of thought affects my emotions really''.

The MWAs felt disheartened due to their current poor work experience. This was fuelled by the lack of control and the exploitation they experienced from senior staff (see 6.4.2.3). Both feelings of powerlessness and the inability to believe that anything can be done to alleviate the effect of stress negatively impacted on the psychological well-being of the MWAs.

Feeling frustrated and de-motivated was another common phrase used by some of MWAs**.** These frustrations were sometimes linked with the level of disrespect and disregard from senior staff. Other contributing factors included a lack of career development and work overload. For instance, Camiye remarked;

> "There are times that I will be so frustrated and just question myself that 'what am I doing here?"

Adunoluwa also said;

> "I was still feeling the ache, and I became really frustrated because of the work I still had to do despite it was already close to the end of my shift..."

Some of the MWAs stated that they lacked motivation due to the continuous exposure to poor working conditions within the maternity settings.

"There is no motivation in this job," Eniola commented.

While other MWAs described their lack of motivation as a response to other sources of stress. For instance, Dayo stated;

> **"**I feel less motivated to do anything again.... because I am too tired. I feel so out of energy, exhausted and downcast".

Bolutife suggested;

> "They (management) need to make us (MWAs) happy you know… That will even motivate one (MWA) to come to work".

The MWAs often attributed their negative experiences at work to feelings of 'suffering'. The MWAs felt they suffered in their job due to the poor working conditions described above. The experience of stress made most of the MWAs describe the hospital as a place they came to 'suffer' at each shift and not somewhere to do a job. Although this was not a major theme within the interview discussions, it was noteworthy within this section that MWAs that reported feelings of suffering were mainly from one hospital. For instance, Monisola said;

> "...what can one (Monisola) do? One (herself) should not suffer at this job and…..''.

Ifeoluwaposi also stated;

> "It is only God that can save us from this farm (hospital regarded as a farm) of suffering."

The MWAs compared working in the hospital to a farm due to the intensity of work and the labour process operating in the maternity setting. The MWAs mostly described coping strategies, which included relying on their religious

faith and hoping that they will one day stop suffering as a result of working as a MWA.

5.5.2 Behavioural impact

The impact of occupational stress was not limited to the physical and psychological aspects of the MWAs lives but also included behavioural reactions either to colleagues or family members. Most of the MWAs described different behavioural reactions, including episodes of emotional outbursts, either directed at their children while at home or colleagues at work. A common behavioural reaction among the MWAs across the three hospitals was a tendency to be cranky and snappy (aggressive) when interacting with colleagues at work. Additionally, the MWAs described different scenarios which contributed to colleagues snapping at each other and this included the exceptionally busy (as described by a MWA) maternity ward and feeling exhausted due to work overload, which led to an over reliance on pain killers. Other behavioural reactions included impatience, irritability and unhealthy life styles, which are discussed below.

The over reliance on analgesia was one of the widely described behavioural patterns among the MWAs and was used as a means of coping with the physical effect of stress. The MWAs used mainly paracetamol/panadol (analgesia) when they felt stressed, irrespective of the symptoms experienced. Most of the MWAs have resorted to using pain killers frequently, sometimes daily. Such was the frequency with which some of the MWAs used analgesia that they explained they needed to have a little bag of medication (not prescribed) for easy access when feeling stressed at work. The MWAs highlighted the use of medication is now at a level where they over rely on pain killers just to alleviate the effects of stress, including body pains and aches. The MWAs described this as the only means available to cope with the physical effect of stress, as they doubted there was a chance of better working conditions in the future. The following MWAs' statements highlighted the problem. For instance, Eniola stated;

> “I now carry my purse of different tablets with me in case I need strong painkillers or panadol on the shift.”

One of the MWAs described the negative effect of using a heavy dose of painkillers had on the body and immune system. Despite being aware of the negative effects of pain killers, the MWAs felt that they did not have a choice but relied on the non-prescribed medications since there was no reduction in the level of stress being experienced. The MWAs also described using these painkillers not only in the hospital but also at home also. For instance, Camiye remarked;

> “I use painkillers a lot even at work and when I get home. This will just help me ease the stress off or deal with the body ache/ headache which are now constant.”

The over reliance of medication among MWAs was relatively high, as some MWAs felt the need to use pain killers at the start of a shift as a precaution against stress. Some of the MWAs also described using painkillers to deal with the effect of inadequate rest. For instance, Monisola reported;

> “...I feel weak that even sometimes I will have to use paracetamol immediately before I can start my work”.

The MWAs now viewed using painkillers as the norm if they were to continue in employment and retain their job within the maternity setting. For instance, Jerisanu raised;

> “I use painkillers a lot and it is because of this job that I started using painkillers heavily”.

Likewise, Eniola described;

> “In my own case I do not know about others, I use a lot of painkillers to deal with aches and pains when I am feeling really worked up and stressed to a point I am beginning to feel weak”.

Due to the lack of concern from senior staff, it could be inferred that the management were not aware of the MWAs’ over reliance on pain killers just to get through a typical working day. Despite raising concerns with management related to the level of stress they were experiencing the MWAs did not receive any response.

The MWAs also described aggressive behaviours, such as feeling cranky when stressed at work and noticed this behaviour in their colleagues. Some of the MWAs outlined different situations when being cranky had affected their relationship with work colleagues. For instance, Ifeoluwaposi reported;

> "I have had to apologise to my colleague because I was so cranky when she (MWA) was asking something. I did not just want to listen because I was feeling so irritated I just snapped at her".

Adunoluwa also stated;
"…and I become upset and cranky with my colleagues."

This behaviour was not only exhibited within the maternity settings but also in the homes of the MWAs. The MWAs described taking their stress into their homes, which impacted negatively on family relations. For instance, Uzomma said;

> "I have reacted before thinking and I snapped at my husband. Ohhh it was not good. I just added to my stress that day. He was so angry…."

Bolutife also remarked;

> "I feel very tired and I can become impatient. Sometimes I could be cranky……., just not myself. I will just feel touchy and emotionally down to the extent I can take it out on my colleague."

Being irritable, impatient and intolerant was another behavioural reaction to stress experienced by the MWAs. Those MWAs that displayed impatience and intolerance described how it impacted more on their family life than work relationships. The MWAs explained that their behaviour mostly resulted in bad relationships within the family. Many confirmed their reactions were not due to their family members but as a result of stress from work. For instance, Olaoluwa said;

> "one (MWA) will be really tired that it will get to a point of irritation and I will just be snapping at the children if they do

something…….and yet they are not the one that put us in this kind of trouble (stress experience) at work."

This illustrated the negative effect of stress on MWAs and the impact it had on their life outside work and work life balance. Though only a few of the MWAs across the three hospitals described displaying such behaviours, it was significantly connected to the sub-theme described above as reactions of intolerance/impatience led MWAs to snap at family members or colleagues at work.

5.5.3 Physical effects of stress

The MWAs also described the physical effects of stress, which included back aches secondary to musculoskeletal disorders while working within the maternity setting. Feeling body aches/pain and headaches was the most common physical effect of stress experienced by the MWAs across the three hospitals sites. Body aches and pains were sometimes exacerbated due to a lack of adequate coping strategies and the constant exposure to occupational stressors, including inadequate equipment within the maternity setting (see section 6.4.3.1). For instance, Yejide said;

> ".... sometimes your (MWA's) body will just be weak, you cannot do anything".

Other physical manifestations/symptoms of stress experienced by the MWAs included profuse sweating, high blood pressure, temperatures, aching legs and chest pain. MWAs also noted sleep difficulty due to anxiety or being too tired to switch off completely when at home. For instance, Jerisanu remarked;

> "I cannot sleep too well because I am too tired and I am working the next day."

These effects will be described below, starting with the most common physical symptoms of stress experienced by the MWAs.

The main reason for these body aches was the MWAs constantly manually handling, including heavy lifting. The MWAs at two of the sites undertook more manual handling than those in the third hospital, yet all reported body aches

due to poor working conditions, including work overload. The MWAs experienced the physical effects of stress in different ways, sometimes simultaneously in various parts of their body, including back pains, muscle pain in the legs/ankle and their body as a whole. For instance, Labake reported;

> "...it is all my body that will be aching. I will be having serious body pain. You know walking up and down.... when there is too much walking through the whole place (hospital), under my feet will be aching me seriously everything will be aching."

Other MWAs, described feeling muscle pain/ache in other parts of their body. Semilanu remarked;

> "ahhhh my body will feel somehow, ahhh my legs but my own major thing is my leg when I wake up in the morning my legs will be aching me seriously".

A major cause of MWAs experiencing this array of physical symptoms was attributed to the lack of adequate/essential facilities, including a lift, within the hospital. Thus, the MWAs were required to do a lot of walking and frequently climbing stairs just to accomplish a task such as going to the laboratory. This was also strongly linked to work overload and staff shortages described earlier, as the MWA on duty on a particular shift had to work alone without any colleagues, attending to the multiple demands from senior staff and patients at the same time. Since the MWAs worked alone there was no means of sharing workload. For instance, Bolutife added;

> "On days I have walked about a lot I begin to feel pains in my upper leg (point to the leg)."

Some of the MWAs also shared their experience of back pain due to heavy lifting. For instance, Temitayo expressed;

> ''..so when the stress is there all my body my legs will be paining me, you see those step (stairs), ahhh they make my body ache me. See my back is not the same again because of all these climbing and coming down''.

These symptoms were mainly attributed to the lack of appropriate equipment used to transport objects and the heavy bins used within the hospitals. Despite the exposure to heavy lifting, the MWAs were not offered any training on manual handling. For instance, Dayo remarked;

> "...see it is at this job I got back ache because of this up and down, carry this carry that…"

Some of the MWAs described experiencing aches in other, different parts of their body all at the same time. According to Wonuola,

> ''My body will be aching me especially my back and my leg. They feel it more, you (researcher) know to be climbing up and down is not easy, unlike other hospitals that have lift''

Headaches and migraines were also constantly experienced by more than half of the MWAs interviewed in this study. During stressful periods at work the MWAs described feeling sharp pains in their head. Thus, due to the high frequency of headaches experienced, this led to the over reliance on painkillers among MWAs. Three quarters of the MWAs described having severe headaches at work. For instance, Eniola reported;

> "When the stress is so much on some days that all my body will be aching with serious headache too, I will just have to use panadol".

Wonuola also said;

> "...and most of the time I have headache, ahhh that one (headache) is now almost every day with this work, the head will be as if it wants to drop".

One of the MWAs described the headaches and bad moods she had at work due to stress and inadequate rest.

Camiye also stated;

> "When you are working and you are having constant headache is that not sign of stress?"

Additionally, Jerisanu remarked;

> “My body is so aching in different places as I am talking to you because as I am trying to rest the body I am back at work again so it is not as if… it is from one pain to another. If my head starts to ache me like this, I will just get Panadol and use it at times before my head falls off. So the stress from this work affects me oh in every area of my body”.

Hasana also stated;

> **“**I am really tired that I struggle to finish my work ah I am completely stressed. The stress has now gone deep into my body…….... Just this morning I was just telling my colleague **********’s mother, that I am really tired, my body is aching”

Another physical reaction experienced by MWAs was high blood pressure (hypertension). Two of the MWAs revealed they had high blood pressure and were diagnosed with hypertension since they had started working within the maternity setting. For instance, Olaoluwa stated

> “It is here (hospital) that I was when I fell sick. I spent two weeks upstairs (admissions) since it is just one person working in the maternity ward. It was then that it was detected that I am hypertensive.”

The physiological impact of occupational stress contributed to the poor health and loss of well-being experienced by the MWAs. This led to some MWAs taking medications regularly to manage their blood pressure, yet they still faced a heavy workload with little or no control over their work and lacked the opportunity to take adequate breaks. Pamilerin also remarked;

> “Before I started this work, I was not hypertensive (slams hand together) both children that I have..... I have never been hypertensive. It was just when I started this job. The pressure, stress and all that...”

The issue of sweating profusely and high body temperature were sub-themes as only a few MWAs mentioned this as a physical consequence of stress. Sweating profusely can also be related with anxiety at work or stressful situations which triggers hyperhidrosis (Benson et al. 2013). For instance, Niniola reported;

> "..sometimes when the work is too stressful ahhhh, even the sweat that will be coming out from my body ahhh it will be very much because when I finish sometimes … in the middle of the night around 2am or 3am I will be so tired..."

They were also exposed to heat stress (poor working environment), which could lead to profuse sweating. The researcher also noted on one of the initial visits to the hospital a MWA sweating profusely while sitting in this store room, although it could not be ascertained if it was due to the heat or stress being experienced. Another less frequently mentioned effect of stress was high body temperatures, noted by one of the MWAs. Experiencing high temperature can be associated with the working conditions operating within the maternity described earlier, including poor air movement. For instance, Temitayo stated;

> ''...even when I am feeling the pain to my bone and I know that this is too much stress, all my body will be hot...''.

5.5.4 Social impact

The experiences of occupational stress not only impacted on the physical, psychological and behavioural aspects, but also on different social areas of the MWAs' lives. This placed a strain on their family and personal relationships within and outside the maternity settings. Most of the MWAs interviewed outlined the adverse effect stress had on their family lives. The MWAs provided different examples of how stress had affected relations with their husband and more particularly their children. The MWAs described not being able to meet their family's needs, including cooking meals or having meaningful interactions with them. Another social impact identified by the MWAs includes having a restricted social life including limited social life with friends.

The MWAs explained that they did not have enough time to spend with their family when they returned home from work due to tiredness or the effects of stress they had experienced. The MWAs described feeling withdrawn from their family. For instance, Pamilerin stated;

> "...now it affects my work at home. It affects my work at home because my children will expect that ahhhh at least their mum will play with them. Then as to what they (children) will eat, I should prepare it but when I get home I will just sit down. I will not be able to do anything."

Other MWAs described sharing their work stress experience with their children, not as a means of coping but as an excuse or the reason why they could not do what was expected of them as a mother. Camiye remarked;

> "There are days I just share it (work issues) briefly with the children but that is for them to understand why I cannot do something for them that evening…since I am too tired"

These experiences have made some of the MWAs feel helpless and worried because they often miss spending quality time or have meaningful interactions with their family, especially their children. For instance, Olaoluwa said;

> "at the end of the day when I get home I will not be useful for myself not to talk of being useful to the children, that someone (she) will just be so tired..."

The MWAs reported experiencing constant exhaustion due to occupational stressors within the maternity setting which led to an anti-social lifestyle. Consequently, the MWAs described not having enough time to socialise with friends outside work, instead they spend the little period they have at home resting. For instance, Labake remarked;

> **"…**really when I get home I do not go around jumping about the place. I do not go places."

A MWA explained that she had to apologise for not being able to attend a function as, despite being off work, she was too tired and would rather rest. This highlighted the impact a heavy workload and the resultant effect

occupational stress had on the social life of the MWAs. This limited the opportunity MWAs had to socialise outside their work environment or build meaningful relationships with people beyond family and colleagues at work. The MWAs found it hard to spare anytime for social functions and this negatively impacted on their general quality of life outside work. For instance, Temitayo noted;

> "As you are seeing me I do not go out to parties. I will spend that time sleeping and resting because I have work to go to the next day again and I am the one that knows how busy it is here. So I use all the time I have to rest oh."

Jerisanu also added;

> "This our job is very busy, too stressful yet there is no time for relaxing or enjoying ourselves again. I cannot go out to parties because I am too tired or just want to rest that day instead of going to parties".

Occupational stress not only impacted on the MWAs ability to maintain personal relationships but also to make future career plans. Most of the MWAs leave work late due to working longer and travel in heavy traffic and these contribute to their experience of stress, reducing the time they have to make any plans or enhance their employability to secure another job. Furthermore, the MWAs are not supported within the maternity setting with training to enhance their employability within or outside the hospital. Although, some MWAs mentioned a training program provided by the HSC, this was not sustained and had limited benefit (see 5.4.5). The poor working conditions and relationships with senior staff also meant the MWAs do not get any type of feedback from working in the maternity setting, which makes it harder for them to appraise their current level of performance in order to identify areas of improvement (if required). Also, the MWAs' lack of optimism about succeeding or making any meaningful achievements within the maternity setting impacted on future career plans. The MWAs experience of stress factors including lack of management commitment to staff development limited the chances of making future career plans.

5.6 Coping and support available to alleviate occupational stress

The previous sections of this chapter described the experiences of and sources of stress and the impact of occupational stress on the MWAs within the maternity settings. This includes the organisational, environmental and the individual causes of occupational stress. The impact of stress was detailed above. This covered issues such as emotional, physical, behavioural and social impacts of stress on the MWAs' health, well-being and quality of life both within and outside the maternity setting. The MWAs employed a variety of coping approaches in order to alleviate and manage the effects of stress experienced at work. However, the MWAs relied heavily on painkillers to deal with effects of stress at work. Adunoluwa said;

> "There is no major approach to coping with stress other than sleeping and using painkillers."

Wonuola also confirmed;

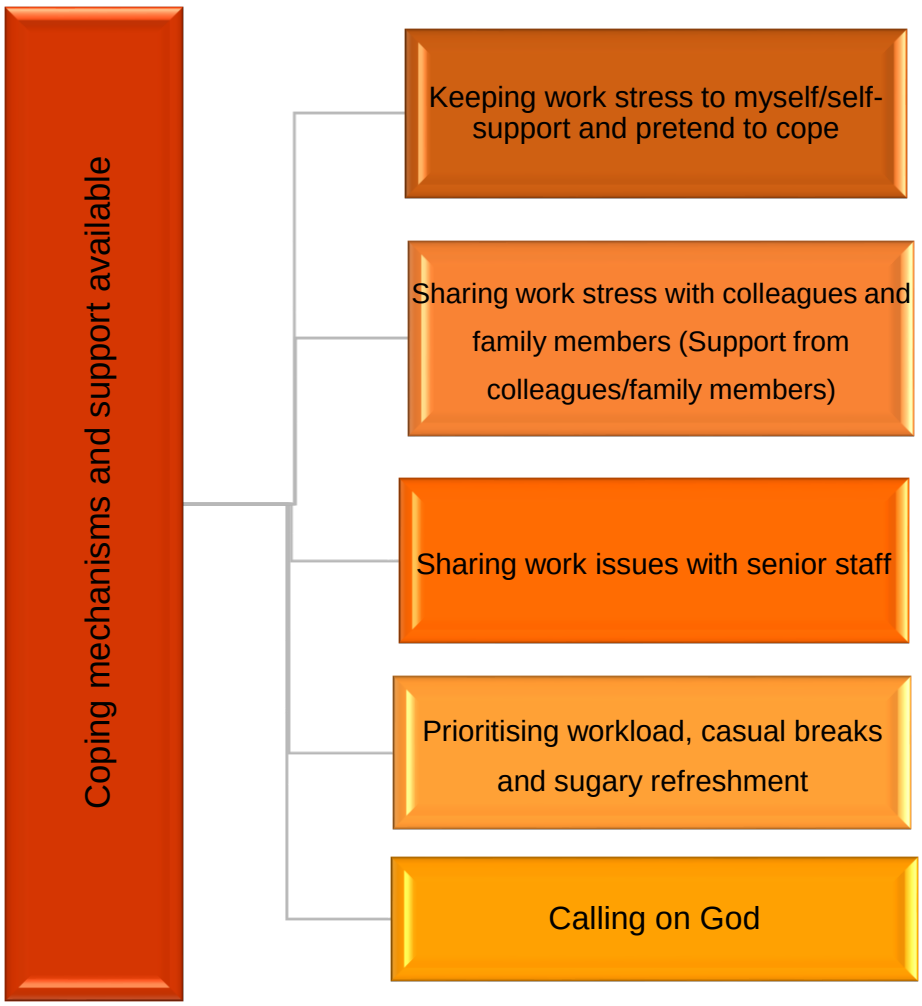
> "…so there is no coping I just do the work and withstand the pain so no coping oh".

During the interviews, the researcher noted that some MWAs described their responses to stress and the methods they used to cope within the same discussions. Generally, the MWAs did not have a specific means of coping with stress and none was provided by their employers. This section will describe the themes that emerged from exploring the coping mechanisms adopted by the MWAs and the support available to alleviate the effect of occupational stress within the maternity settings (see diagram 8 below).

The MWAs described different coping mechanisms they used to alleviate the effects of stress experienced while working in the maternity setting. This includes keeping the stress to themselves, pretending to cope or sharing their stress with colleagues or family members. Basically, these were the two main approaches adopted by the MWAs but they often also used other practical day to day measures which where applicable within their work setting. It is noteworthy that some of the themes described below play a dual role, both as the behavioural manifestation of stress and a coping strategy. This was

because some of the coping mechanisms used by the MWAs were the result of the physical or behavioural reactions or due to effects of stress. The area of support was explored during the interviews with the MWAs. Questions concerning this focused on their perception of the support available (if any), the people they turned to for such support and if it had any beneficial effects in alleviating occupational stress. The MWAs gave different views about the support available within and outside the hospital setting. However, the most commonly referenced source of support was that received from their family outside work and colleagues within the maternity settings. The themes emerging from exploring these main areas will be elaborated below.

Diagram 8: Themes that emerged from exploring the coping and support available to alleviate occupational stress



5.6.1 Keep work stress to myself/self-support and pretend to cope

The MWAs described that in some situations they kept their stress to themselves or pretended to cope before attempting to share their experience with colleagues (if any were available) or family members when they returned home from work. For instance, Boluwatife stated

"I support myself ahh".

Fifoluwa also commented;

> **"**Here if you do not look after yourself, it is not their (management's) business if you fall or faint…**"**

It was inferred from the MWAs' responses that the fear of being verbally abused or insulted by a senior member of staff contributed to them not being willing to share their experiences of stress when at work and developing coping strategies to support themselves (see exploitation by senior staff). The MWAs described that there were also situations when they did not feel like talking because they were too stressed and emotionally drained. For instance, Hasana said;

> "There are times I will just want to keep what I am going through to myself. On such days I do not feel like talking probably because I am too tired…"

Dayo also added;

> "There are days I just keep it (work stress) to myself and just deal with it while I go on with the shift."

Additionally, Ifeoluwa commented;

"I keep it to myself, carry on working and doing my duties…."

The impact of keeping stress to themselves resulted in other behaviours being exhibited by the MWAs, including aggression. Thus, the MWAs often felt unable to share their stress although they wanted to, as they were constantly exposed to stressors within the maternity setting.

Another reason stated by the MWAs on deciding to self-support at work was that they felt the management were not responding to their pleas or complaints and that this was an indication that they were not willing to offer any help with their job. Kitan commented;

"They will not even answer when we ask for anything. So I support myself."

Some of the MWAs also described how they carried on working as if nothing was wrong with them. The lack of appropriate channels to complain or seek help was a contributory factor to MWAs pretending to cope with stress. The MWAs described pretending to cope with stress or a heavy workload just to keep their job or avoid been verbally abused by senior staff if they complained. This was a common situation across the three hospitals and MWAs were struggling and not always managing their stress due to lack of appropriate coping mechanisms. For instance, Eniola remarked;

> "...if coping means just carrying on with the work and doing all you can, then I just carry on with it. This job you (MWAs) just have to do what you (MWAs) can to keep yourself"

Olaoluwa confirmed;

> "I will just be struggling with it and carry on with the pretence that there is nothing wrong, I will continue doing my work like that …."

5.6.2 Sharing work stress with colleagues and family members (support from colleagues/family)

Some of the MWAs kept their stress to themselves, others described sharing their experience of stress mostly with their colleagues or other ward attendants from different departments within the hospital. Although there is normally only one MWA per shift, some MWAs seized the opportunity during handover or /shift change to share their day's stress with their colleagues. The MWAs also described sharing 'a laugh' together when discussing the day's work or a stressful experience. This inferred that the MWAs attempted to use humour as another means of coping with stress. However, many of the MWAs

emphasised the limited time with colleagues was mostly eroded by the lack of control over their job and heavy workload. For instance, Semilanu remarked;

> "……normally we talk to each other (MWA) here. If I meet my colleague or I go to another ward to do something I can just mention it that ahhh I am tired ohhh the work today is too much something like that. I can just say that and she (colleague) too can tell me she is feeling the same way too…. so that is how we do it really".

Uzomma also stated;

> "It is with my colleagues that I can say I share what I am going through at this work because it is only one person per shift doing all the work so I can talk to my colleague upstairs if we meet or if she comes to my ward we will be together in the store. We will talk while we are trying to rest for some time."

Camiye added:

> "It is only we attendants (MWA) who try to help ourselves. We talk about it and keep ourselves going at the job."

Other MWAs also felt they shared their stress issues with colleagues mainly because there is no one else to talk to in the hospital. For instance, Jerisanu said;

> "ahhh who do I want to share it with here. There is no one to talk to now. OK maybe my colleagues and that is because we do the same work and we know how the work is"

The MWA often felt sharing their experience of stress with colleagues was the best means of coping while at work and it helped them feel relieved when they had the opportunity. This was because their colleagues could relate to and understand what they were going through at work. For instance, Eniola remarked;

> "You know sometimes it (sharing with colleagues) also helps to get some of it (stress experience) off your chest. It even makes me feel

better sometimes talking about how I feel with my colleague since we do the same thing, we (MWAs) understand each other"

The fact that MWAs identified with the same problem or were able to share work stress with each other was one of the key supportive mechanisms the MWAs identified. For instance, Fifoluwa remarked;

"My colleagues are good. They try in their own little way to support me, at least that we (MWAs) do for each other. Even if it is when we talk to each other to encourage ourselves during the shift and they help when they can."

Likewise, Eniola stated;

"The only support I have at work are from my colleagues, nothing from the management or doctors; instead they will add more work to your work."

The MWAs felt they got support from their colleagues when they offered help with carrying out some small tasks, including delivering blood bags to the laboratory.

The MWAs also saw their family as the best support network they had outside the hospital.

"In fact they are the best support I have," Uzomma confirmed.

This was because the MWAs found it easier to discuss their work issues or stress experiences with their family members, particularly, husbands, and a few of them with their children. For instance, Kitan said;

"...I take whatever is wrong with me from work to my house, I discuss it with my family, especially my husband. Ahhhh I tell him everything when I get home because I get home, even as tired as I am once I just have my bath again and eat, I will just be talking ..."

Jerisanu also added;

"If I cannot share it at work, I take it home (laughs). I will share my work with my family. I think now my family know that when I am

> getting home I will just start to talk about how tired and busy work was."

This was the main type of personal support the MWAs could get since they did not have enough time to make friends or socialise outside work, as stated earlier. For instance, Eniola remarked;

> "Then my family is the one that support me most with this job. When I start my complaining like this they (family) will listen, help me get my food, put water in the bathroom, they just help me. They care for me when I get home especially my husband and the older children."

Gbemisola also stated;

> ".... They (family) support me and care for me when I am telling them I am really tired they listen and offer help where they can. They support me….."

Dayo commented; "the best form of support comes from my family."

Other MWAs described sharing their experiences of stress with their children for different reasons. For instance, Fifoluwa said;

> "When I share it (stress experience) with the children, I just use it to encourage them and plead with them to face their studies so they can work in higher positions."

5.6.3 Sharing work issues with senior staff

The MWAs often described senior staff as people in authority who were unapproachable. Some MWA described sharing work issues only with the 'nice' nurses/midwives. Although there was no clear explanation of who was a 'nice nurse/midwife', it was understood to be certain midwives the MWAs felt were 'approachable' and with whom they had a 'good rapport' or shared a sense of 'human feelings'. The MWAs described not sharing their work stress with some of the senior staff because they felt they did not want to listen and

also for fear of being disrespected or labelled as 'lazy' for complaining. For instance, Ifeoluwaposi stated;

> "…...except for a few nurses that will listen or that have human pity in their hearts. The others I cannot share anything"

Dayo also remarked;

> "Just like I said if I am working with a nice midwife I can share it with her. Like tell her (midwife) I am really tired and she will just encourage me that it is the job but try to rest and all that."

Some of the MWA preferred to talk to midwives they felt more comfortable sharing their work stress with. Fifoluwa commented;

> "There are some midwives I have shared my stress with in this hospital and are approachable. There is one particular one, Mrs ******, she will advise me on what to do when I get home to relax myself more…. There are very few like that I do talk to. They would also advise that we should not be managing and struggling through the stress that we should complain…..but..."

Generally, the MWAs have identified the midwives they could talk to as 'nice midwives'; however, they did not describe any benefits from such discussions. Furthermore, approaching the doctors was not an option because they were perceived to disregard/disrespect the MWAs. Gbemisola remarked;

> "The doctors are just a no go area, those ones are just too proud so I do not cross their part except they want me to do something for them"

Jerisanu also noted,

> "Here (hospital) they are very good with insults. Since we did not go to school we keep hearing a lot of insults even from junior doctors. It is very terrible."

Dayo said;

> “The doctors especially the junior doctors are even rude; they will talk down on you (MWA) instead of support you”.

It was unclear if this perception was applicable across the three hospital sites, as none of the MWAs mentioned sharing work stress with the doctors within the maternity setting. Hence, a lack of senior staff or an adequate pool of people to discuss difficult work situations with was perceived to contribute to the experience of stress amongst the MWAs.

Generally, the MWAs did not expect much from the management or senior staff because, despite knowing the stressful nature of their job and how stressed they often were, they felt their employers failed to help. For instance, Kitan said;

> “See I believe it is one thing for the job to be stressful and another thing is the people I am working with too do not help at all. The ***, they (midwives) are not helpful....”

Hasana noted;

> “We have complained and complain, even wrote that they should provide new stretchers but they will not”.

Fifoluwa also remarked;

> **“**Nothing from our employer oh. They do not support us in anyway nothing like support. If they support I will not be complaining now.**”**

Despite the MWAs feeling less supported, one of the MWA had a different perception on support from senior staff in terms of resources provided. Yejide stated;

> “They (management) give us our instrument to work they give us mop, broom and nylon to put in the dust bin so it is not messed-up”

5.6.4 Prioritising workload, casual breaks and sugary refreshment

The MWAs generally did not have a particular approach to coping with heavy workloads but described making attempts to prioritise their job demands where possible. For example, the MWAs often attempted to prioritise their workload at the start of their shift but explained that they were often unable to stick to their plans due to constant interruptions mostly from senior staff or other work demands. For instance, Fifoluwa described;

> "…I try to but it does not work all the time here and we (MWAs) cannot do anything about it at all. When I am needed, I go..."

Labake also commented;

> "….ahhh you……just like I mentioned the things I said before all the cleaning and mopping but even when I try to do it like if an emergency delivery comes in now, you know I will have to leave what I am doing and go to the labour ward because I know very soon they (midwife) will need my attention there. So before the midwife calls for me I am ready to attend….so I just quickly pack things to one side …. I will come back to it."

Furthermore, while some of the MWAs made an attempt to prioritise their workload, other MWAs have abandoned the idea and just work according to the demands within the maternity setting. For instance, Gbemisola said;

> "……. because it (priority plan) will scatter now (laughs), when I say OK I will start with sweeping and dusting, then a nurse calls me I have to go now. I cannot say wait I have to finish sweeping, no oh. So I do the work as it comes when I am needed I go then return to do my own work afterwards".

The inability to prioritise work can be linked to the staff shortage (discussed above) and MWAs were unable to share their workload effectively. "Casual breaks" was a common concept used by the MWAs' across the three hospitals. There were no official 'breaks' and the MWAs relied on 'casual unauthorised breaks' taken as at when.

The MWAs often described seizing opportunities to have casual breaks and to sit for a few (5) minutes, either in the storage room or on another ward when on an errand to relax when extremely tired. The MWAs described doing this to help catch their breath or rest before going back to work or to use such times to have a quick meal or snack if possible (see lack of meal breaks 6.4.3.2). The MWA explained that this was their break in the absence of a scheduled time to rest during a shift. However, the MWAs described getting called from breaks as described above. For instance, Fifoluwa said;

> "What I do is that when I see that I am not doing any major work, I will just sit in our store and rest for some few minutes or maybe eat my food if I brought food or bread and tea."

Dayo also remarked;

> "There are times that I know I cannot continue. I just need a break of 5 to 10 minutes. I can just sit maybe at the laboratory …. or in one of the departments I am doing clearance at because I might not be able to sit at my ward when I get there. So it is just to rest briefly, not for long; if not I will just be delaying my work too."

The MWAs often took sugary drinks or refreshments, both as a behavioural effect of stress and a coping mechanism. The MWAs described taking sugary drinks just to cope when they were stressed and feeling exhausted. This contributed to the MWAs living an unhealthy lifestyle, a behavioural effect of stress. The issue of unhealthy eating habits and sugary drinks was strongly linked to the lack of scheduled breaks or meal times at work, as described earlier, which resulted in MWAs eating plain bread as a snack instead of a proper meal. The MWAs explained that plain bread was easier to access without the need to take time out to eat it and they could have this between tasks when not directly involved in delivering patient care.

Additionally, the MWAs reported not having a proper meal because they were either too tired to eat, when they returned home often falling asleep on the sofa or not having enough energy after work to cook. Another reason for the MWAs' unhealthy lifestyle was linked to not having a place/fridge to store their food at

work and food perishing. Thus, the MWAs described relying on sugary drinks or chewing on plain bread to get through their shifts. The MWA's experience can be seen in the quotes below. Dayo said;

> "Sometimes I bring food to work and there is no time to eat it or fridge to keep it so when I am going I throw the food away".

Olaoluwa also stated;

> "...since I started my shift and I have been working ahhh see the Pepsi (Fizzy drink) that I was drinking and the food I was about to eat before they (midwife) called me that I dropped it (the food) …. You (researcher) can see I cannot eat it again"

Gbemisola remarked;

> ''I like to drink too maybe drink water or drink maltina. The maltina (fizzy drink) gives strength too.... cold tea ah that will help. Once I drink it, it will boost my system from inside, the coldness will cool me inside.''

As a coping mechanism, Jerisanu remarked;

> "…. if I am at work and I am feeling like I will drop the next minute because that happens from time to time, I will be feeling very exhausted with no energy left, if I have money I can just buy coke, you know it has sugar and it can boost energy ahhh I will just use that to help me continue my work."

Likewise, Niniola also stated;

> "I finished sometimes in the midnight around that, 3am or sometimes 2:30am ahhh I will just take one maltina or one coke to relax me"

5.6.5 Calling on God

The MWAs working in the three hospitals represented a combination of Christians and Muslims. Although the MWAs practised different religions, they relied on their religious faith to sustain them and some commented that it was

only God that helped with their experience of occupational stress. The MWAs continue to practise their individual religion despite working on their days of worship (Sunday for Christians and Fridays for Muslims). The researcher noted that there were more Christians than Muslims but all shared a common trait of relying or calling on the God they worshiped. Rininuola said;

> "…. we (MWAs) are just praying that God makes it easy for all of us (MWAs). We are just struggling along with it (work stress) and we pray that God allows it to lead to somewhere good."

Furthermore, some MWAs also felt the reward of their work could only come from God because they were not appreciated or rewarded by the senior staff or the hospital management. So the best they (MWAs) could do was look up to God for solace. This could also be attributed to different biblical or Islamic doctrines on faith the MWAs anchored on to support themselves at work. For instance, Kitan commented;

> "It is God that can reward us at this job..... God should have mercy, they (management) are not doing us well at all in this place."

Likewise, Ifeoluwa remarked;

> "…. only God that can save us from the stress of the work. It is too much. In fact, it is terribly much."

Jerisanu also stated;

> "The thing is that there is no one to fight for us or help us here and it is only God we have that I can hold on to with this work".

Labake added;

> "So it is only God that can give strength to do the work. That is why when we are coming to the work you pray to God that he gives you the strength and might to work. There is no rest at all here. It is only God that can give us rest"

However, while some of the MWAs specifically emphasised relying on God for help, other colleagues referenced God within their discussions. For instance, Olaoluwa remarked;

> "I told her (midwife) God will do it, we will make the contributions and we will buy the fan. Should it be like that ehn"

Monisola also commented; “it is only God that is having mercy on us”.

5.6.6 Excerpts from my reflective diary: Interviews

When thinking about my approach to data analysis an entry in my reflexive diary demonstrates the benefits of a qualitative method as follows:

This manual analysis is quite time consuming but this approach is quite fulfilling. I keep referring back to the original transcripts time and time again re-immersing myself in the world of the MWAs throughout data analysis.

I have just listened to my first interview recording and everything is coming back again like the MWA is speaking directly to me all over, it is fresh again.

Although I was aware that for some time it has been a Nigerian cultural norm for some to treat subordinate workers unfairly, I thought that given the need to work together as a team within a maternity setting this would not be the case. I was not prepared for the accounts of poor treatment and disrespect shown to uneducated women of lower social status. This provided something of a challenge and brought the concept of feminism into sharp relief.

The themes of being uneducated and being shown disrespect became obtrusively recurrent.

Hearing a MWA’s, experience of her miscarriage made me empathise with what they were going through at work. I just finished another interview during which a MWA described how she had a miscarriage and had to return to work while she was still in the early days of recovering. I thought to myself, *how strong this woman is* despite all she has gone through, she is still very hard-working and manages to smile from time to time during this interview. However, most of her superiors are women and I just wonder why she was

allowed, indeed expected to return back to work despite what she has just experienced? I found a number of questions running through my mind. Did she tell her employers of the real reason for her absence? Was she able to do so? However, I had to ensure I maintained my role as a researcher and did not trigger emotions that would be difficult to respond to and that perhaps were not appropriate given the interview setting.

I noted this day; 'How brave are these women, despite their experience within the maternity ward, they are able to share this with someone they do not even know. I felt I needed to do something as an individual, for instance enlightening the senior staff about the need to give these women some time off work or try to offer support but I had to refrain from losing focus of the interview and digressing from the whole experience I was exploring',

I had to prioritise their reasons for revealing such details over my intrinsic feelings and thoughts and minimise the risk of misinterpreting the essence of the information and the interview itself.

I have just interviewed a MWA and it is past her home time. It was a good interview despite just finishing a long night shift, She still had the energy to give me detailed information and was happy to finish the interview, even though she knew it was going to take about an hour or more to get home. She reminded me of how resilient these women are.

It has become more obvious that the Nigerian culture to exploit people still prevailed very much, illustrated by a MWA lifting heavy items on her head at work. Working in this way surely should not be part of the MWA job description, there is clearly no such tangible document. I guess this is my Western exposure coming to light. I need to refocus.

I have just finished an interview with a MWA who definitely had so much to say and her passion to work within the maternity ward came through, despite her challenging environment. However, I was glad and somewhat relieved on a personal level that she also mentioned how hopeful (anchored on God) she was of a possible change.

Today, I had the rare privilege to see what the doctors room looks like which ironically is opposite the store where the MWAs have made their rest place, as and when they get the rare opportunity during a shift. It was a very sharp contrast to the MWAs room (store), the doctor's room has an air conditioning unit and a water dispenser while the MWAs' room didn't even have a fan. In that one moment the irony of being a subordinate staff member suddenly became more evident.

I have conducted my last interview but I feel I should continue listening to these women because it was a privilege for me to be a listening ear. They all wanted to talk and I got this impression that they have been waiting to have someone to listen to them. I have my PhD to write up and hopefully my recommendations will lead to a change.

It is quite amazing how I have become to an extent immersed in this group of workers and developed empathy for this group of women. Despite not being a MWA I felt that I established a good rapport with the MWAs and the interviews were honest, open, rich and fruitful.

Although, I am aware of religious beliefs in Nigeria, it was interesting to hear that the MWAs also brought this into their work setting. This was highlighted by the use of religion in everyday conversations.

I was surprised to know these women didn't have a social life despite the Nigerians being known for their love of parting and socializing**.**

5.7 Summary

In summary, this chapter provided a detailed description of the themes that emerged from exploring with the MWAs the four main areas within this study. These areas were the experiences of occupational stress, sources of stress, the impact and the coping mechanisms and support available, mainly from colleagues and very little from senior staff within the maternity settings of hospitals in Nigeria.

These areas provided the answers to the research questions which will be discussed in Chapter 6. The data collected from the MWAs' interviews provided a valuable insight into the stressful working conditions in the maternity settings within the three hospitals participating in the research study. The findings revealed that the MWAs were fully aware of the level of stress they were exposed to. Interestingly, in contrast to existing studies, death and dying were not a prominent cause of stress among the MWAs despite being exposed to rare, unfortunate incidences of maternal mortality. This finding contrasts with previous studies that recognised death and dying as a significant stressor (Healy and McKay 2000; Kipping 2000; Stordeur et al. 2001; Peter et al. 2013).

The biographic data gathered for this study established that all the MWAs were women working within the maternity settings of the federal hospitals. Only two hospital sites employed a few male assistants (porters), who work alongside the MWAs (see 5.1). The MWAs role involved a variety of duties which were mainly domestic. The MWAs had different levels of education, from National Diploma to Primary certificate level. The majority of the MWAs had over 5 years' experience within the maternity and one MWA had only worked for 6 months within the hospital (see 5.1). It was established that this group of MWAs were a mixed population of vast experience within the maternity setting and clearly understood their role.

It was established that staff shortages, working long hours and work overload were the major factors that contributed to occupational stress among MWAs. This was closely followed by role expectation, lack of support from senior staff/management and poor equipment/resources. The impact of these occupational stressors was also highlighted as MWAs experienced some significant consequences, not only on their health and well-being, but also other aspects of their social life. The MWAs had headaches, body aches and tiredness as the physical effects of stress within the maternity settings. Other less frequently described physical effects included profuse sweating and high blood pressure. Although these were not among the main effects of stress, they are significant due to the detrimental consequences for health if not properly managed. As a result of these symptoms the MWAs relied heavily on analgesia to alleviate the physical effects of stress. This was also noted as a behavioural effect of stress. Other behavioural responses to stress included aggressive outbursts towards family members and colleagues.

Low self-esteem, hopelessness, feelings of suffering and sometimes anxiety were the most commonly cited emotional effects of stress among the MWAs. This mainly led to emotional exhaustion among MWAs. Overall this resulted in the MWAs having a limited social life and withdrawing from family members.

All these effects of occupational stressors contributed to the negative experiences of MWAs working within the maternity settings. This was further compounded by the lack of appropriate support and coping mechanisms, as discussed above. Although colleagues and family support was highlighted as beneficial where and when available, there was limited support from the MWAs' employer. However, the MWAs described adopting individual coping strategies, including keeping stress to themselves or pretending to cope and also sharing concerns with colleagues or family members. Some MWAs were able to share work issues with senior staff; however, this was not common practice due to fear of verbal abuse and insults from midwives. Other day to day approaches to alleviate stress included prioritising workload, taking casual breaks and drinking sugary refreshments. While some of these approaches were adopted as a coping mechanism it led to MWAs having unhealthy life

styles. Interestingly, there was a significant reliance on faith/God as a means of coping with stress among the MWAs, irrespective of their religion. This was established as a mechanism based on the operational cultural system of MWAs practising different religions and following the principles of their individual doctrines.

The next chapter provides an in-depth discussion of the themes highlighted above with reference to what is already published in relevant literature.

CHAPTER 6 DISCUSSION OF FINDINGS

6.1 Introduction

This chapter discusses the key findings from the main areas explored in the present study and reflects on the literature reviewed previously to provide a clearer understanding of the lived experience of MWAs. It is worth reiterating that there is a dearth of research on occupational stress that focuses on MWAs compared to studies on midwives, nurses and doctors. This hindered a like-for-like comparison. Therefore, while applicable relevant studies will be used within this discussion chapter, caution will be exercised when making reference to them. This chapter concludes with a summary of the discussions and its place within the literature.

Before discussing the results and relating it to relevant literature, a brief recap of the main findings of the current study is presented below. Within this study, four main areas were explored (see Table 2):

- The MWAs' experiences of occupational stress
- The sources of stress
- The effects or impact of stress on the MWAs' health and well-being
- The support and coping mechanism available for MWAs within the maternity setting.

Key themes emerged from the main areas explored which were underpinned by sub-themes (see Chapter 6).

Experiences of occupational stress among the MWAs were defined by their perceptions of what 'stress meant' to them individually. The MWAs indicated that the main source of stress included work overload, staff shortages, poor work organisation, hazardous working environments, difficult relationships with senior staff and poor salaries. The effects of these occupational factors varied among MWAs, leading to an array of physical, psychological and behavioural symptoms, including physical pain described by them as 'aching bodies', low-self-esteem and poor social lives. Despite the consequences of constant exposure to stress, the MWAs lacked adequate support at work. The

MWAs relied on their colleagues, themselves and family members for support. Thus, the MWAs engaged mostly in coping strategies that included unhealthy eating habits and an over-reliance on analgesia to alleviate the effects of stress. Fortunately, this study presented the researcher with an opportunity to give a voice to these unrecognised women, the MWAs who played a key role within the maternity service.

6.2 Demographics of Maternity Ward Attendants

The study population was MWAs who worked within the hospital maternity settings in Nigeria. In total, 22 MWAs were interviewed. All the MWAs were female. This gender composition was similar to their counterpart Maternity Support Workers (MSWs) in the United Kingdom (Lindsay 2004). There is a paucity of research involving MSWs and the little that is available does not elaborate a great deal on the gender and general demographic composition of respondents. However, the literature suggests that the majority of MSWs who support midwives, a predominately female workforce, were also female (Lindsay 2004; Kennedy et al. 2010). Within this study all the MWAs worked full time as there was no option for flexible working. This was in contrast to their colleagues in the UK who have the opportunity of flexible working as required by law (GOV.UK 2016a). In terms of education or formal qualifications, the majority of MWAs had O' level certification and only a few were educated beyond this level. None of the MWAs had undertaken any form of training relevant to their current role within the maternity setting. In contrast, in the UK despite the fragmented nature of MSW trainings, there has been notable progress towards developing programmes to support this role with emphasis on the educational development for MSW, for example the All Wales Maternity Support Worker Curriculum (2008) (Lindsay 2004; Hussain and Marshall 2011). Some MSWs have undertaken training specific to their roles and others have obtained National Vocational Qualification (NVQs) at level 1, 2 or 3 (Lindsay 2004). The National Health Service Trusts in the UK endeavour to recruit MSWs that have at least NVQ level 2, with a commitment to further training and development (Lindsay 2004; Griffin et al. 2009). While the difference in the structure of the heath service in Nigeria and that of the

UK is acknowledged, a similar commitment to training and development in Nigeria is absent, something that is urgently required.

The age of the MWAs varied from 26 to 56 years, with an average age of 36 years. The majority of the MWAs had between 3 and 5 or more years' experience of working within the maternity setting. The little research undertaken on MSWs gave no information about their age and work experience, which hindered comparison with the current study (Griffin et al. 2009). However, Thornley (2008) stated that the majority (over four-fifths) of HCA/support workers generally were female and around half of them work part time, are aged over 40 and nearly a third have between 10 and 28 years' experience.

The majority of the participating MWAs worked a combination of shifts (16-hours night shifts and 8 hours morning shifts). These hours were often extended due to workload demands and, in Nigeria, the government did not pay for extra hours worked. Due to the lack of flexibility, only 9% of the MWAs worked permanent morning shifts with no option to do permanent nights. In contrast, 12 hour shifts, including a combination of shifts patterns (not limited to night and morning shifts) was the longest shift pattern found in the UK, the USA and Europe (Ball et al. 2014).

6.3 Role description

Due to the limited research on MWAs, the researcher was keen to understand this role and the tasks carried out from a Nigerian perspective. The MWAs described their duties within the maternity setting as mostly domestic and included sweeping, mopping, patient discharge and running errands for pregnant women, new mothers, doctors and midwives. However, some of these duties, including collecting patients' plates/dishes, were not originally part of the MWAs' role. These duties were added to the role due to staff shortages in other departments. Only a few of these duties were similar to those performed by their counterparts in the UK, such as laboratory runs and acting as runners on the labour ward (RCM 2012). While MSWs performed

few clerical duties, they supported midwives, including assisting mothers with breast feeding, contributing to antenatal care, obtaining mothers' urine samples and assisting the midwifery team during procedures (Tope et al. 2006; Griffin et al. 2009; Hussain and Marshall 2011). The duties delegated to MWAs varied and largely depended on the midwives they worked with in the hospital. In contrast, in the UK midwives delegated duties to MSWs but this process was largely aided and defined by published national guides, including the Guide to the Roles and Responsibility of MSWs (Griffin et al. 2009; RCM 2012). A similar approach needs to be adopted to ensure role clarity and consistency in delegatiing duties to MWAs across hospitals in Nigeria.

6.4 The Maternity Ward Attendants' experience of occupational stress

The first main area explored was the MWAs' experiences of stress. As previously stated, there is a dearth of literature that explores the lived experiences or perceptions of stress among healthcare workers and none relating to MWAs. The majority of studies that did examine stress adopted quantitative approaches (Mark and Smith 2012). Although these studies defined stress using different theories and models, most researchers examined the causes and effects without fully exploring individual perceptions of what occupational stress meant (Calnan et al. 2001; Bianchi 2004; Alves 2005; Chen et al. 2007; Dewe et al. 2012; Jain et al. 2013).

The approach adopted in this study makes a unique contribution to the body of knowledge, establishing what stress meant to the MWAs, before exploring the consequences for health and well-being. However, comparing the MWAs' perceptions of stress in Nigeria to the findings of other studies was difficult, as these studies were conducted with diverse populations, dissimilar research participants and different working environments (Mackin and Sinclair 1999; Cronqvist et al. 2001; Currid 2008).

The following discussion will focus on the meaning of stress, how MWAs knew they were stressed, and opportunities MWAs had to discuss stress with their colleagues. Additionally, it will focus on employer policies related to stress.

The MWAs' definition of stress was explored. More than three quarters of the participating MWAs demonstrated an understanding of occupational stress and were familiar with the phrase. The MWAs described their perception of stress mainly in the context of how they reacted to work stressors. Stress experienced by the MWAs in this study was interpreted as transactional (Lazarus and Folkman 1984). There was a unanimous view that stress contributed significantly to their undesirable experience of working within the maternity settings. This finding was similar to midwives' experiences within maternity services in other countries (Ball et al. 2002; Evenden and Sharpe 2002).

The meaning of stress to the MWAs was also set in the context of their personal experiences and the volume of work. The main meaning of stress emerged when the MWAs described their work as 'stressful' in itself. This was mainly attributed to factors such as a busy maternity ward and the enormous amount of pressure put on them by senior staff and management. Based on this, the MWAs perceived that stress was caused by their work environment and excessive work duties. These factors will be discussed later in this chapter.

The frequency with which MWAs felt and noticed stress was also explored. Two thirds of the MWAs experienced high levels of stress at work and described feeling stressed on every shift. This supports the findings from a study conducted in Malawi that reported high levels of burnout due to occupational stress among maternity health workers (Thorsen et al. 2011). Healy and McKay (2000) and Flanagan and Flanagan (2002) also reported similar findings. Burnout being attributed to a cumulative and excessive exposure to occupational stress (Maslach et al. 2001). Another study reported high levels of occupational stress among junior nurses (not in maternity settings, but in Nigerian hospitals), which was attributed to increased delegation from and exploitation by senior staff (Lasebikan and Oyetunde 2012), a situation not dissimilar to that of the MWAs. The high level of stress experienced by the MWAs was further exacerbated by their lack of control over their job. This was congruent with findings from previous studies (Kirkcaldy

and Martin 2000; Evans 2002). For instance, nurses in general practice reported that a 'lack of control over their job' contributed to their experiences of stress (Calnan et al. 2001). Additionally, Curtis et al. (2006) conducted a study of midwives who indicated their intention to leave midwifery practice. The reasons cited were a lack of control and their inability to practice the standard of midwifery care they wanted to.

The importance of job control for releasing an individual's potential and increasing performance through satisfaction has been recognised within the management literature (Jones and Fletcher 2004). However, despite this recognition there continues to be growing concern in relation to the negative impact a lack of job control has on an individual's health and well-being and on organisations more generally. For instance, Jensen et al. (2013) noted that low/lack of job control limits an organisation from reaping the full benefits associated with high performance work practices (HPWP). This implied that individuals who lacked control over their job might feel they are getting less from the job, while still expected to do more with greater effort (Jensen et al. 2013). This view challenged the high performance work practices because if such an expectation is without sufficient amount of job control, this will result in deleterious consequence for individuals, such as role overload and increased pressure (Kroon et al. 2009). This supports the job demand-control theory that proposed a strain occurs when there are high demands and low control (Karasek 1979). However, while HPWP was not a practice in Nigerian hospitals, the MWAs implied there was a high performance expectation from the management, despite lack of control and training initiatives for individual MWAs.

The MWAs also noted that they experienced certain symptoms, including physical body pain and mood changes which signalled that they were stressed. MWAs occasionally attributed these symptoms to their lack of job control. These symptoms were mostly attributed to the physical and emotional impact of stress (Section 5.5). Arguably, the MWAs' experience of the effects of stress were similar to those described widely in the literature (Cottrell 2001; Edwards and Burnard 2003; McVicar 2003; Gelsema et al. 2006; Chandola et

al. 2008). These impacted on the MWAs' perceptions of working within the maternity setting. The majority of MWAs were less positive about their experiences because of the poor working conditions within the maternity setting. This was supported by earlier studies that reported working conditions within maternity hospitals as being a major source of stress among midwives (Mackin and Sinclair 1999; Curtis et al. 2006).

Despite the high levels of occupational stress experienced, the MWAs were unable to take time off work, which they felt contributed to their overall dissatisfaction with the role and general experience of work. Although it could be expected that the turnover rate would be high among MWAs due to their constant experience of stress, an interesting finding within this present study was that there was low staff turnover. This differed from previous studies that reported increased levels of stress were linked to high staff turnover (Nabirye et al. 2011; Donovan et al. 2013)**.** The only explanation for the low turnover of MWAs was Nigerian job insecurity. The MWAs explained that leaving their job was not an option, due to the current levels of high unemployment in Nigeria. As noted previously, the MWAs described their current job as an opportunity to be employed, therefore they would rather endure the effect of stress, including musculoskeletal pain, than not work. This implied that due to the fear of losing their job, the MWAs engaged in presenteeism and worked despite being ill or stressed (Letvak et al. 2012). Studies have reported different factors associated with presenteeism, including inflexible work schedules and high job demands (Demerouti et al. 2009). For instance, a study conducted among nurses in a Portuguese public hospital reported that, despite feeling sick and experiencing musculoskeletal pain, they still had to go to work (Martinez and Ferreira 2012). This was attributed to a lack of control over their jobs, staff shortages and job insecurity (Crout et al. 2005; Martinez and Ferreira 2012). This was similar to the experiences of the MWAs in the present study.

A culture of presenteeism was often exacerbated by the absence of management policies that penalised staff who took sick leave or managers who formally or informally disagreed with sick time. As MWAs noted, 'taking

time off work' was almost like a taboo and sick leave was often frowned upon by senior staff and management (Feilder and Podro 2012).

The employer's policy on ensuring health and well-being with reference to stress was explored. From the descriptions provided by the MWAs, it was evident that their employers did not have a policy that protected staff health and well-being. In contrast, in Western countries there are regulations and standards protecting the health, safety and well-being of staff and offering support to individuals experiencing stress, such as permitting time off work (Health and Safety Executive 2014). These management standards were developed to promote employee health and well-being and prevent illness while at work, including stress. This stress related guidance reflects the legislative framework and management standards, which consist of the Health and Safety at Work etc. Act (1974) and the Management of Health and Safety at Work Regulations (MHSWR) (1999) (Health and Safety Executive 2014). For instance, under the MHSWR (1999) employers in the UK are required to carry out assessment of significant health and safety risks, including the risk of stress-related ill health arising from carrying out work related activities (HSE 2013) . Despite this, a high rate of staff turnover and absenteeism due to stress has been reported within the UK health care setting (Kirkcaldy and Martin 2000; Clegg 2001; Health and Safety Executive 2012; Mark and Smith 2012). Nevertheless, employers are aware of their responsibilities to employees and a similar approach could benefit MWAs within Nigerian work settings.

Furthermore, the MWAs explained that despite their stress, their employers did not provide any care or support. The issue of support will be discussed later in this chapter. However, with the aging workforce, the continuously poor working environment and current experiences of stress within the maternity setting, the MWA role continues to be challenged (Adegoke and van den Broek 2009; United Nations Populations Fund 2010). Many of the MWAs continued working to support their families, due to lack of other job opportunities. However, if measures are not taken to recognise the individuals within this crucial role and enhance their work experience, there is a possibility of less people willing to take the job in the future.

6.5 The sources of stress to Maternity Ward Attendants

The second main area explored was the sources of MWAs' stress within the maternity setting. In order to determine these factors, the researcher asked the MWAs the following questions:

- What do you find most stressful at work?
- What do you think are the possible causes?

The MWAs described an array of duties that caused occupational stress within the maternity setting and distinguished those deemed most stressful. These were mostly manual handling tasks. However, patient discharge and laboratory runs were common tasks across the three hospital sites that were highly stressful. These duties could not be compared to findings in other studies due to the paucity of research on MWAs in this region and differences in the populations of existing research. A notable difference is that MWAs work alone, in contrast to their colleagues (MSWs) in the UK for instance, who work with other MSWs. However, only a few of these duties were similar to those performed by the MWAs' counterparts in the UK (RCM 2012). Five main themes emerged which described the causes of stress among MWAs (Table 2 and Diagram 6). These themes will guide the discussions below.

6.5.1 Organisational factors and professional working relationships

The first group of sub-themes that emerged was shift patterns and long working hours. More than three quarters of the MWAs described staff shortages, long working hours and work overload as the most impactful occupational stressors. These factors were interwoven, as one stressor would result in the occurrence of another. This supported the findings from a number of international and national studies (Trinkoff et al. 2006; Arikan et al. 2007; Moustaka and Constantinidis 2010; Ladan et al. 2014). These studies identified long working hours and shift patterns as common stressors in the nursing and midwifery professions. However, while nurses and midwives in these studies associated working 12 hour shifts with high levels of stress, this was worse for MWAs who worked an official 16-hour night shift. This was consistent with a study that found that the longer their shift, the greater the

stress perceived by registered nurses working within a hospital setting in Michigan (Hoffman and Scott 2003). The MWAs were in agreement that they regularly had to work longer than their official 8 and 16-hour shift due to being unable to complete their work (work overload) or staff shortages. This finding in the current study was consistent with studies that described long working hours due to staff shortages as one of the stressors that impacted on nurses' health and well-being, and the quality of care provided (Geiger-Brown et al. 2004; Rogers et al. 2004b; Keller 2009; Burtney and Buchanan 2015).

Working long and extended hours often led to burnout among midwives and poor retention rates (Arikan et al. 2007; Mollart et al. 2013; Yoshida and Sandall 2013). Said et al. (2015) and Wu et al. (2011) reported that working long hours negatively impacted on quality of life and increased the burnout experienced by nurses in a paediatric setting. This was consistent with the current findings as the MWAs explained that their long working hours impacted negatively on family relations and their ability to get adequate rest. However, the findings of Wu et al. (2011), Yoshida and Sandall (2013) and Said et al. (2015) also showed that long working hours led to poor retention of staff and high turnover rates, however, this contrasted with the findings of the present study. As stated earlier, the rate of turnover among the MWAs in Nigeria was low due to the lack of opportunity for career advancement within the maternity settings. However, while a like-for-like comparison could not be achieved due to variations in research populations and settings, it was inferred that the issue of long working hours was general to the hospital setting irrespective of location. A lack of working time regulations also contributed to the MWAs working beyond 12 hours on a single shift.

The second group of sub-themes that emerged within this factor was that work overload lead to role expansion. Consistent with the current study, workload was identified as a major cause of occupational stress in the nursing literature (Healy and McKay 2000; Lee 2003; Lambert et al. 2004; Chang et al. 2006; Sveinsdóttir et al. 2006; Weyers et al. 2006; Prowse and Prowse 2008). Increased workload was attributed to growing levels of occupational stress experienced not only among nurses and midwives, but also by healthcare staff

in general (Smith et al. 2000; Lee and Wang 2002; McVicar 2003; Bianchi 2004; Garrosa et al. 2008; Glazer and Gyurak 2008; Li and Lambert 2008). These studies consistently demonstrate the adverse effect of increased workload on healthcare workers' physical and mental health. Earlier studies also described workload as a major cause of occupational stress within the maternity setting (Wheeler and Riding 1994). Arguably, the issue of heavy workload persisted across the hospital and maternity setting irrespective of individual profession or location. At the same time, workload was repeatedly reported to be a major contributor to midwives and nursing assistants' experiences of stress and job pressure (Chappell and Novak 1992; Smith et al. 2009; Thorsen et al. 2011).

However, the issue of work overload for the MWAs in the maternity setting was compounded by other contributing factors, including role expansion, unequal delegation of duties and the duplication of work. The MWAs often had to cover different maternity wards during a single shift due to staff shortages or annual leave. The MWAs stated work overload occurred partially due to constant interruptions from senior staff. This was consistent with the Spooner-Lane and Patton's (2007) study among nurses in Queensland. The study used a mixed method design with nurses within this study reporting that their excessive workload was caused by increased paper work and constant interruptions from health professionals or from other work demands. While the MWAs did not have to deal directly with paper work, they were involved in patient discharge duties which often interrupted their work. This was echoed by mental health nurses in Wales, who reported that experiencing too many interruptions when they tried to work was stressful (Edwards et al. 2000).

Increased work overload and exposure to occupational stress has resulted in a decline in job satisfaction, not only among nurses and doctors but also MWAs. This finding was supported by Nabirye et al. (2011) who found that high levels of stress impacted negatively on job satisfaction among Ugandan nurses. The limited studies conducted among nurses and other health professional in Nigeria also reported work overload as a major cause of occupational stress (Mojoyinola 2008; Ladan et al. 2014).

The role of the MWAs in Nigeria has evolved over the years without a proper review by senior managers. This is in contrast to the role development process described by Armstrong (2006) and Boxall and Purcell (2011) who describe a more consultative agreement where competency requirements are discussed and mutual understanding of new expectations achieved (Armstrong 2006; Boxall and Purcell 2011). The issue of role expansion contributed to increased workload and intensification of MWAs' work. This was supported by Green (2004b), Bach and Edwards (2013) and Long et al. (2014). Similar findings were reported among nurses who took on a more 'hands on' medical care due to reductions in junior doctors hours (Cooke 2006). Arguably, this led to increased workload and work intensification, not only among nurses but also HCAs, who dealt with the devolved bedside duties (Lindsay 2004; Kessler et al. 2006; Doherty 2009). These researchers argued that support workers had to take on more of the nurses' and midwives' delegated duties which increased the pressure on them and expanded their roles. This argument was consistent with findings in the present study. However, the MWAs' role expansion was exacerbated by other factors, including the lack of official contracts or formal job descriptions. In some hospital sites, MWAs had dual roles as MWAs and also as cleaners due to staff shortages.

Thus, the MWAs' role boundaries were very blurred. This created potential role stress as the MWAs' role was overloaded and widened to deal with shortfalls in other departments. This is supported by Prowse and Prowse (2008) who noted the role of MSW is expanding to incorporate the midwives' caring duties which were often reluctantly relinquished to take on more technical roles undertaken by doctors. This was corroborated by McKenna and Slevin (2007). The issue of role overload was often associated with increased symptoms of work stress leading to burnout among nurses (Kipping 2000; Stordeur et al. 2001; Santos et al. 2003; Kelloway and Day 2005; Garrosa et al. 2011). The reports of these studies were consistent with the current findings.

There was a notable difference between what the MWAs were employed to do and the duties actually performed within the maternity settings. Similar findings

were highlighted by Wu et al. (2010). Chang and Hancock (2003) and Chen et al. (2007) also reported that role expansion contributed to low job satisfaction among newly qualified nurses. These findings supports the current study as MWAs expressed a great level of dissatisfaction with their role and often made them feel frustrated and depressed. This implied the issue of role expansion is a global problem experienced in different forms due to general staff shortages. Nevertheless, the issue of staff shortages in the maternity setting in Nigeria was also due to management's reluctance to recruit staff to fill the vacuum left by retired MWAs.

The third group of sub-themes that emerged within this factor was made up of role expectation, poor staffing levels and staff shortages. The issue of staff shortages or inadequate staffing was also reported as a stressor among midwives that ultimately contributed to some midwives' decision to leave the profession (Curtis et al. 2006). Hughes et al. (2002) stated that midwives identified poor staffing levels as a stressful experience which led to low morale within maternity services. This supported the current findings, as MWAs were often made to work harder to compensate for staff shortages and contributed to their feeling overwhelmed and unable to cope adequately with stress.

Decreased health care budget also contributed to increased workload for health workers. Since 2010, the Nigerian government has not been compliant with an agreed pledge at an African Union meeting in Abuja to commit at least 15% of its budget to health spending (KPMG 2012). Instead, the Nigerian government committed less than 5% of its budget to the health sector.

The persistent staff shortages in Nigerian hospitals increased manager's expectations of the MWAs role, who often took on more duties within the maternity setting. Thus, such demands played a major role in the detrimental effect of stress on the MWAs' health and well-being. This was supported by Stordeur et al. (2001), Piko (2006) and Kelloway et al. (2008). Despite these stress levels management did not take any duties off them. The MWAs also highlighted the different expectations senior staff, including doctors and midwives, had of their role and the conflicting perceptions of what their duties entailed.

The above discussion revealed how interwoven the outlined stressors were within this study. This was supported by Lambert et al. (2004), who suggested that as one workplace stressor increased, so did the others. Hence, there was an urgent need for senior management to resolve issues around role overload and reduce the level of stress experienced by the MWAs. This was also suggested by Peters et al. (2012). Effionm et al. (2007) also noted that role clarification for non-nurses was required to reduce the stress experienced within Nigerian hospitals.

Additionally, the MWAs experienced stress at work due to poor working relationships with senior staff and management. This finding was consistent with some Nigerian studies conducted among nurses in the hospital setting (Mojoyinola 2008; Ladan et al. 2014). Despite the difference in populations, it was confirmed that poor relationships between senior and junior staff increased the level of occupational stress experienced within the hospital. Interpersonal or professional working relations have repeatedly been identified as a major stress factor across cultures among healthcare workers, specifically midwives, nurses and doctors (French et al. 2000; Lee 2003; Sveinsdóttir et al. 2006; Mojoyinola 2008; Nyssen and Hansez 2008). Arikan et al. (2007) also reported that difficult interpersonal relationships between nurses and physicians contributed to the levels of stress experienced by nurses. MWAs felt other factors contributed to poor working relationships, including lack of support, limited input in decision-making and lack of respect from senior staff. This was similar to findings reported in Chan and Huak's (2004) study.

The participating MWAs experienced a lack of recognition as part of the maternity team. Evidently, there was no teamwork within the Nigerian maternal service. This contrasted with practices in countries, including the UK and the US, that advocate multidisciplinary team work (Leonard et al. 2004; Cornthwaite et al. 2013). Lack of recognition as a team member was a cause of concern for MWAs, as senior staff often abused the authority associated with their positions. Nevertheless, lack of respect and recognition from doctors was highlighted as a major job stressor among nurses (Spooner-Lane and Patton 2007). Thus, Spooner-Lane and Patton (2007) noted that lack of

recognition and undervaluing nurses' skills and experience, specifically by disrespectful doctors, increased stress. Similar findings were noted by Murphy (2004), Arikan et al. (2007) and Hayes et al. (2015). This could be inferred to be consistent with findings in this present study as MWAs described feeling undervalued despite playing a key role within the maternity setting. This also contributed to the sense of inequality the MWAs experienced with the senior staff. Similar findings were also reported among nurses (Spooner-Lane and Patton 2007; Alotaibi 2008). Although the afore-mentioned studies also described a high turnover among nurses due to the lack of professional respect and recognition by administrators and doctors, this was in contrast to the current findings. Both recognition and mutual respect from leaders was suggested as a means to improve communication and reduce stress among nurses (Stordeur et al. 2001).

In addition to contending with disrespect, the MWAs were subjected to unrealistic and competing demands. This was associated with the perception that midwives and doctors taking advantage of their seniority over the MWAs. As noted earlier, the MWAs felt unable to say 'No' and were threatened with accusations of insubordination, including being labelled as lazy. This made the MWAs feel helpless and powerless and they lacked the opportunity to share their feelings with management. A similar situation was reported by Rowe and Sherlock (2005). While exploitation by senior staff is not reported in the literature, the issue of verbal abuse among nurses or midwives has been noted, mainly from patients and occasionally from doctors (Arikan et al. 2007; Spooner-Lane and Patton 2007). This was in contrast to findings in this current study, as verbal abuse from mothers or their relatives was not reported by the MWAs. Instead, the MWAs were complimented for their hard work by the relatives observing them. However, Rowe and Sherlock (2005) noted that nurses in Philadelphia experienced more verbal abuse than doctors because of their subordinate status.

Another dimension of the poor working relationships experienced by MWAs was the lack of support and understanding from senior staff and management. For instance, lack of support from senior staff was specifically linked to high

rates of occupational stress among nurses in different hospital units (Pikó 1999; Bakker et al. 2000; Callaghan 2003; Curtis et al. 2006; Berland et al. 2008; Konstantinos and Christina 2008). Specifically, Bakker et al. (2000) commented that lack of support contributed to emotional stress symptoms experienced among nurses. Similar findings were also described by Healy and McKay (2000) and Hayes et al. (2015). These were consistent with the current findings and confirmed that lack of support remains a significant stressor, irrespective of professional status.

Despite earlier studies highlighting the issue of poor working relationships as a major cause of stress, this continues to be problematic and to impact on the health and well-being of health workers, including MWA (Guppy and Gutteridge 1991; Wheeler 1998; Chan and Huak 2004). Dallender et al. (1999) noted that nurses who reported stress-related problems were those who received the least support and frequently ended up working by themselves. This supports the findings of this study as the majority of MWAs worked alone and often did not receive any form of support from the midwives they worked with during their shifts. A lack of co-operation and communication among staff contributed to the absence of support for the MWAs. The issue of poor communication was consistent with other studies (Lee and Wang 2002; McGrath et al. 2003; Sveinsdóttir et al. 2006). Thus, Dallender et al. (1999) suggested that improving the quality of communication between staff and senior managers was crucial to enhancing working relationships. Farrell et al. (2006) also concluded that nurses within their study dealt with stress more efficiently when they received support at work. Similarly, Bartram et al. (2004) found that the nurses identified a lack of support from their leaders, which was a significant cause of stress. This was also supported by Stordeur et al. (2001), who reported that tyrannical and control oriented leadership increased the stress experienced by subordinates. Thus, the findings from this present study were consistent with earlier research and confirmed that poor professional relationships increased the level of occupational stress experienced by MWAs, irrespective of hospital location or setting. This implied that strategies should be directed at improving levels of support and enhancing professional relationships and communication within the hospitals.

While the issue of leadership was not a specific theme, it can be inferred that there were positional leaders among senior staff and management. Evans and Choucri (2012) noted that this style of leadership often provides little potential for midwives to work together towards a common goal to enhance the quality of care for mothers and babies, and improve levels of job satisfaction. Moreoften, individuals subjected to positional leadership follow instructions out of a sense of duty with no opportunity to provide input. Positional leadership can also result in limited opportunities for self-development (Evans and Choucri 2012). Although, the MWAs were not specifically mentioned by Evans and Choucri (2012), their work provides valuable insight into the extent to which leadership styles can be influential in increasing staff motivation and job satisfaction, and in reducing stress and emotional exhaustion within the maternity services. Hence, Evans and Choucri (2012) identified the need to build effective staff relationships that can influence change and promote health and well-being for mothers and their babies.

6.5.2 Resources and governance

Among the occupational stressors described by MWAs were the issues of resources and governance, which focused on inadequate equipment and shortage of working essentials, lack of meal breaks and control over time. These stressors impacted on MWAs due to the effect it had on their ability to perform duties and on their health and well-being. Consequently, these factors, alongside the stressors noted earlier, resulted in pressures that MWAs found difficult to cope with at work.

Only a few studies identified lack of equipment and insufficient resources as work stressors (Glazer and Gyurak 2008; Jones 2014). Despite this, Callaghan (2003) undertook a qualitative study in Scotland and reported that lack of resources in the ward contributed to low morale, which led to stress among nurses. Bianchi (2004) also listed limited material resources as a cause of stress among nurses. The lack of resources sometimes also compromised the quality of patient care. These compromises, feeling coerced, and having to practice below best standards, led to nurses feeling stressed (Lee and Wang

2002; Lee 2003; McGrath et al. 2003). These findings were consistent with the current study, as MWAs also described performing certain duties below their preferred standards, for instance cleaning with limited chemicals.

Management had high expectations of the MWAs despite the limited resources provided, and this contributed to the difficulty encountered by the MWAs in accomplishing a task. This was supported by Currid (2008) who noted that lack of resources contributed to the nurses' inability to meet managers' expectations. This led to the nurses feeling overwhelmed and stressed at work. Similar to the current findings, the nurses also reported that resource shortages led to working in a dangerous environment where staff and patients were put at risk.

The current findings were consistent with the few studies conducted in Nigeria (Effionm et al. 2007; Anyebe et al. 2014). These identified poor equipment and inadequate supplies in government hospitals as major stressors among nurses. Similarly, inadequate resources and lack of healthcare facilities contributed to occupational stress among nurses working in Iranian hospitals (Adib-Hajbaghery et al. 2012; Mosadeghrad 2013). Although the settings were different from that of the current research, these findings were consistent with the present study. It could be inferred that, irrespective of geographical differences, lack of resources and inadequate facilities created a stressful working environment for healthcare staff.

Lack of meal breaks and control over work time/hours within the maternity setting were key governance issues that stressed MWAs. The MWAs explained that they had limited time for meal breaks owing to their heavy workload and lack of control over their work (see Section 7.4.1). Findings from the current study were consistent with studies that reported that nurses were unable to have meal breaks or took shorter breaks, mainly due to heavy workload (Khowaja et al. 2005; Witkoski and Dickson 2010). Other studies found similar findings, also among nurses. For instance, Trinkoff et al. (2006) conducted a study to explore the effects of meal breaks on staff. Their findings highlighted that nurses did not have enough time to take a meal break during their shifts because they were so busy. This contributed to nurses' experiences

of occupational stress and errors due to fatigue. Similar findings were described by Rogers et al. (2004a) and Witkoski and Dickson (2010). These were consistent with this present study's findings as MWAs also reported feeling weak and exhausted due to lack of breaks during shifts. Additionally, Ladan et al. (2014) stated that infrequent breaks and too much responsibility contributed to stress among nurses in Nigerian hospitals. Furthermore, staff shortage contributed to MWAs inability to take meal breaks. This was because there were no staff to cover the ward when they needed a break. A similar situation was reported among nurses by Spooner-Lane and Patton (2007).

The evidence shows that providing scheduled meal breaks promotes occupational health and reduces an array of adverse workplace health outcomes, including stress (Silverstein and Clark 2004; Trinkoff et al. 2006). The MWAs are in a worse situation due to the lack of policies or regulations mandating meal breaks in Nigeria, in contrast to countries like the UK. For instance, in the UK it is compulsory to have at least 20 minutes break if working for more than 6 hours a day (GOV.UK 2016b). Other requirements for meal breaks were specified within the Working Time Directive issued by the European Union (GOV.UK 2016b).

Another factor that influenced the lack of meal breaks was that they were not recognised by senior staff and management. This was a contributory finding as only few studies have been undertaken to explore the influence of management support for meal breaks on health and well-being. Nevertheless, this was consistent with Khowaja et al. (2005). A recent study conducted in Boston teaching hospital reported low psychological distress among nurses. This was associated with the increased frequency of meal breaks and managers support for this practice (Hurtado et al. 2015). Thus, the findings suggest that having regular meal breaks or a pause from work could positively affect mental health, an opportunity the MWAs in this study were not provided.

6.5.3 Environmental factors

In addition to the factors described above, environmental issues were among the key causes of stress for the MWAs. The MWAs listed exposure to infection, hazardous work environments and unfit work base as the major environmental issues that caused stress at work.

Exposure to infectious diseases, mainly from needlestick and sharp injuries, was one of the major environmental factors that caused anxiety among the MWAs. This was due to the fear of contracting any disease or infection that would be transmittable to their families. The main reason for this exposure was the lack of appropriate personal protective equipment (PPE) and health and safety training. Adams (2012) noted that needlestick (NSI) and sharp injuries commonly occur among nurses and healthcare professionals in general. For instance, Ball and Pike (2008) carried out a survey among 4407 nurses in London, where it was estimated that 48% of nurses had sustained NSI injury. A similar finding was reported in the US where more than 1000 healthcare workers was estimated to contract serious infections, including hepatitis B or C, from an NSI annually (Trinkoff et al. 2008). However, due to poor record management systems in Nigeria, the exact figures of similar occurrences could not be presented. Nevertheless, it could be suggested that similar, if not higher, rates of NSI incidences occurred in Nigerian hospitals, including the maternity setting. It could therefore be inferred that these reports were consistent with the current study. The MWAs expressed significant concern over their exposure to serious and sometimes life threatening risk of blood-borne infection. This contributed to the MWAs' work stress experience. While it was understood that the above studies were conducted in different settings, Trinkoff et al. (2008) commented that healthcare workers irrespective of setting were at risk of infections from NSIs.

Furthermore, Adams (2012) reported that the psychological effect of an NSI on healthcare staff was significant, leading to emotional responses, including excessive anxiety. Thomas and Murray (2009) also noted that even when strict universal precautions were followed, the occurrence of such an injury was stressful. These studies support the current findings. Therefore, it was inferred

that the MWAs were at a greater risk of contracting such infectious diseases. The possibility of such occurrences was higher due to the lack of adequate precautionary measures within the maternity setting and training on the safe disposal of needles. This presented a more critical situation for the MWAs than recounted in previous studies.

Another factor that contributed to stress was a hazardous working environment. As stated earlier, this was often attributed to used needles being carelessly discarded on the ward floor by senior staff, including the doctors. Also the MWAs worked amidst broken infrastructures, including shattered windows, or with potentially dangerous equipment, such as broken stretchers. This resulted in MWAs sustaining injuries.

The issue of poor infrastructure/unfit staff areas and hazardous working conditions was less frequently noted as a stressor in previous studies. This may be attributed to the majority of studies that have been conducted in settings with developed infrastructure, as described previously. Furthermore, studies of stress often analysed these factors broadly within work environmental stressors, including environmental relationships and physical workload demands (Stordeur et al. 2001; McGrath et al. 2003; Sveinsdóttir et al. 2006; McGibbon et al. 2010). This provided only limited clarification of specific physical aspects of the environment that were stressful. Nevertheless, excessive noise, poor lighting and safety hazards were listed as physical environment stressors (Long et al. 2014). This was partially consistent with the current finding as, despite such circumstances, the MWAs had to ensure high performance was achieved. The MWAs worked in hazardous conditions including using unsafe ladders to reach heights and cleaning dangerous objects without PPE. This was partially consistent with a study that reported that missing and faulty equipment contributed to stress experienced among nurses and doctors in a renal setting (Jones 2014).

Additionally, the MWAs stated that their chosen staff base was unfit for the purpose of rest or relaxation from their busy routine nor was it suitable for consuming refreshments. This was closely linked to lack of recognition and

unsupportive practices from the management. The MWAs were deprived of a proper work base and had to convert a storage room to serve both functions. This experience was rarely described within the literature. Nevertheless, consistent with the current findings, a study conducted in Nigeria among nurses identified poor physical conditions at the hospital, including heat, as being among the causes of stress (Anyebe et al. 2014). Similarly, poor ergonomic design of patients' beds and nurses' stations contributed to physical stress and other injuries among health staff in the USA (Ulrich et al. 2004). The MWAs' storage room/ work base was in a dilapidated condition, characterised by poor lighting and ventilation. This was consistent with the afore-mentioned studies. This also contributed to MWAs feeling neglected by the management, compared to the treatment received by the senior staff. This was partially consistent with a study that reported inadequate staff areas; poor air quality and lighting contributed to low morale among ward staff within NHS trusts (Totman et al. 2011).

Earlier studies also noted that physical and busy work environments contributed to stress among healthcare workers, including nurses (Pikó 1999). Other studies described the issue of busy wards or work environments within the context of the heavy workload discussed earlier. Furthermore, Santos et al. (2003) found that the physical work environment was a contributory factor to occupational stress experienced among nurses in Missouri. Despite some consistency with a few international studies, overall the findings from this study highlighted the differences between hospitals in developed and developing countries. This reinforced the need to develop organisation-specific interventions to ensure their effectiveness in alleviating occupational stress globally.

6.5.4 Human resource management factors

Human resource management was the fifth factor that caused stress among the MWAs. Sub-themes included poor remuneration and lack of reward, lack of career growth advancement and discrimination in recruitment.

The MWAs described being paid poor salaries and not feeling rewarded for their work efforts within the maternity setting. The lack of reward was associated with working long hours, some of which were unpaid. This was consistent with other studies that identified low wages and lack of reward systems as major stressors among nurses (Lee and Wang 2002; McGrath et al. 2003; Bianchi 2004; Alotaibi 2008; Glazer and Gyurak 2008). These issues resulted in the MWAs feeling unappreciated and unrecognised for their efforts within the maternity service, despite the growing staff shortages. Consistent with this study, nurses described lack of recognition and appreciation from supervisors and physicians as a major cause of stress within the hospital (Alotaibi 2008). The MWAs expressed a great sense of displeasure at the poor remuneration they received, which contributed to job dissatisfaction and low morale at work (see Callaghan 2003). Additionally, the MWAs described feeling that their salary did not reflect the effort and work done within the maternity setting. A similar finding was described by Mosadeghrad (2013). Congruent with this study, such imbalance between reward and effort was described as stressful by healthcare workers in a public hospital in Zurich (Hämmig et al. 2012).

Another finding from this present study was the issue of inconsistencies in yearly incentives noted by the MWAs. No other research examining MWAs has reported incentives as a stressor and this highlighted the cultural and organisational differences of the setting addressed within this study.

The issues of poor salary and lack of reward have also been noted in different studies investigating occupational stress using the effort-reward imbalance (ERI) model. For instance, Akanji (2013) argued that the poorest organisational outcomes stemmed from effort-reward imbalance (ERI) which was conceptualised by Siegrist (1996). Thus, when an individual's hard work was not reciprocated with adequate appreciation or financial entitlement it caused staff to feel stressed (Arikan et al. 2007). Drawing on this theoretical perspective, it was inferred that there was no reciprocity between the effort expended and the reward attached to the role of a MWA.

Additionally, a lack of opportunities for career development was experienced by the MWAs. This was often due to a lack of training or opportunities to progress beyond their current role. Consistent with this study, the lack of training or development and poor career progression were identified as major stressors among nurses (Lee 2003; Glazer and Gyurak 2008). Furthermore, the perception was that management did not support the MWAs to improve their employability status. Although this was not often mentioned as a major stressor, it was highlighted in other studies involving healthcare staff (Bakker et al. 2000; Callaghan 2003; McGrath et al. 2003; Piko 2006; Sveinsdóttir et al. 2006). Callaghan (2003) noted that despite the emphasis placed on career advancement, there was a general lack of support and limited opportunity for progression, which contributed to nurses' frustration. This supported the finding within this study in that MWAs often felt stuck in their current job role (see Colligan and Higgins (2006).

This issue of career growth and advancement was also associated with the politics that operated within the hospital. In addition to the limited training opportunities, the MWAs were disadvantaged due to political selection by the recruiting board. This was a contributory finding within the field of occupational stress. The politics in recruitment and discrimination centred on promoting or recruiting unqualified staff. This issue of politics and discrimination (selecting favourites) was not limited to the MWAs as this is a common practice within the Nigerian hospital system (Obuah 2010). Recruitment and selection were perceived to be dysfunctional and lacked transparency on required criteria to succeed. This was in contrast to other areas, which offered MSWs opportunities to advance, including recommendations to undertake training without bias in the selection process (NHS Employers 2006; Griffin et al. 2009).

The current findings in relation to Lazarus and Folkman's (1984) theory of stress and coping as detailed above stipulate that stress occurs when there is a perceived (appraised) discrepancy between the demands of a situation and the resources the individual has to deal with such situation. The present study supports Lazarus and Folkman's (1984) theory of stress providing significant

insight into the major factors that contribute to stress from the subjective perceptions of MWAs.

In relation to the present study, the MWAs appraised their experiences of work mainly as a threat to their health and well-being. The key themes relating to work organisation and staff relationship within the maternity settings significantly highlighted how, for instance, working long hours and dealing with heavy workload that exceeded the MWAs' capacity resulted in stress.

In most cases, the MWAs felt their situation was uncontrollable and drew on methods or behaviours they believed could minimise the impact of such stressful situations. Although the MWAs used various methods of coping, this only provided a short-term relief and proved more detrimental to their health, such as taking sugary refreshment. This approach to coping could not be related to problem-faced coping and leaned more to emotion-focused coping which aimed at reducing the negative emotions of the effects of stress, including the physical impact (Payne 2001). Furthermore, since from an organisational perspective there is no means of eliminating the threat or stress, the MWAs tend to adjust their emotions and just carry on working. This resulted in MWAs exhibiting negative behavioural reactions, including snapping at co-workers. In addressing the symptoms of stress, the MWAs continue to rely on coping methods, including calling on God and talking to co-workers or family members. This current finding re-affirms Lazarus and Folkman's (1984) theory of stress and the need to have an in-depth understanding of respondent's experiences and subjective perceptions of stress and the coping mechanisms adopted by individuals.

Although this present study did not intend to explore burnout, the current findings had some implication in relation to Maslach's Burnout theory (Maslach and Jackson 1981). This theory is multidimensional, with three core constructs: emotional exhaustion, depersonalisation and reduced personal

accomplishment. This clearly placed the MWAs experience of stress within a social context. In summary, job burnout is a response to chronic and prolonged exposure to work stressors (Dewe et al. 2012). This reiterates Maslach et al. (2001) description of burnout as a chronic response to cumulative long-term negative impact of work stress, when job stress appears to be unavoidable for the individual and sources of relief are unavailable. Thus, in relation to the current findings, it could be inferred that the MWAs were on the verge of burnout due to their perceived lack of control over their job, the continued presence of work stressors which has led to emotional exhaustion coupled with their perceived lack of accomplishment and, feeling trapped in their role. The MWAs often expressed feelings of exhaustion believing that their energy was 'used up' without any adequate or proper means of replenishing it. These experiences represent the key dimensions of burnout. However, the issue of burnout will need further research to affirm this conclusion.

6.6 Impacts of occupational stress on Maternity Ward Attendants

The third main area explored within this study was the impact of stress on the MWAs' health and well-being. From this area four main themes emerged: emotional/psychological, behavioural, physical and social impacts (Diagram, 7). These themes have been described in the literature as inter-related and overlapping but not mutually exclusive categories (Kelloway et al. 2008). The MWAs described an array of health symptoms resulting from multiple stressors, these symptoms included physical body aches and living an anti-social life style (Table 2). These symptoms formed sub-themes that underpinned the four key themes and will be used to structure the discussion below.

Numerous studies have linked excessive occupational stress with the increased probability of physical and psychological health issues (Edwards and Burnard 2003; McVicar 2003). Furthermore, the experience of stress was noted to alter the way an individual felt, their thinking patterns and behaviours which led to changes in their physiological functioning (Cox et al. 2000). This has also been attributed to decreased job satisfaction, poor patient care and

the undesirable effects on the health and safety of workers (Nabirye et al. 2011; Jordan et al. 2013). The majority of these findings were partially consistent with the current study, as detailed below.

6.6.1 Emotional and psychological impact

The first theme reflected the emotional and psychological issues associated with stress as experienced by MWAs. The MWAs used an array of expressions to describe their emotional reaction to stress at work, including feelings of suffering and helplessness, frustration, anxiety and low self-esteem. A combination of these factors contributed to the MWAs' feelings of low self-esteem, specifically lack of recognition, unfair treatment and the inability to share their stress experiences with senior staff. This was consistent with Long et al. (2014) who found that unfair treatment led to stress and impacted on the self-worth of nurses in private hospitals in Malaysia. Fairness was referred to as the quality of treating staff equally or in a reasonably right manner to avoid a series of negative or stress related outcomes (McCann et al. 2009). This was in contrast to the current findings due to the MWAs being treated unequally to other staff, including a lack of concern from management.

The emotional effect of stress has been described in several international studies but those from a Nigerian perspective are limited (Healy and McKay 2000; Chan and Huak 2004; Chang et al. 2006). These international studies reported that the existence of stress predicted lower levels of mental health among healthcare workers, including nurses. Consistent with other studies, feelings of helpless and anxiety was cited as an emotional effect of stress among MWAs (Healy and McKay 2000; Lambert et al. 2004; Weyers et al. 2006). Callaghan (2003) reported that work stressors, including lack of participation in organisational decision-making and unclear work directions resulted in frustration for health workers. Similarly, Arikan et al. (2007) noted that work related stress mainly due to heavy workloads and conflict with senior health staff, contributed not only to feelings suffering, but also to helplessness. The participating MWAs reported experiencing similar helpless and anxiety on an almost daily basis and this was exacerbated by their unsupportive working

conditions with no prospect of improvement. The MWAs' frustration was consistent with Hinno et al. (2012). Similarly, Donovan et al. (2013) commented that continuous stressful situations triggered emotional responses, including anger and depression when poor working conditions or events appeared unmanageable.

An important finding from this present study was the feeling of suffering described by the MWAs. This was often attributed to the MWAs' lack of control over the intensity of work. Similar findings suggest that nursing assistants generally had less control over their workload and thus were at higher risk of depression (Geiger-Brown et al. 2004). It can be inferred that this group of workers experienced a lack of control due to their low status in the hospital hierarchy and managements' attitudes towards them. Additionally, Karasek and Theorell (1990) noted that there was a risk of psychological stress when a decrease in control over increased workload occurred. This type of working environment and intensified labour process was perceived as a stressful experience for the MWAs. Consistent with Berland et al. (2008), a stressful work environment and a lack of support created a problematic situation for nurses, which made it harder to cope with stress.

This current findings was also supported by studies that noted that stress led to other psychological reactions being reported by the MWAs, including mood disturbances, irritability and frustration (Healy and McKay 2000; McGrath et al. 2003; Gelsema et al. 2006). Jones et al. (2013) noted that the emotional effects of stress, including anxiety, contributed to reduced work performance and ultimately burnout. Although decreased work performance was not addressed within the study, it could be inferred from discussions with some of the MWAs. However, due to poor relationships with senior staff, the MWAs could not admit decreased work performance as this might lead to them being insulted or losing their jobs. Emotional exhaustion in relation to the effects of stress and an attribute of burnout was also exhibited by the MWAs (Maslach 2003).

6.6.2 Behavioural impact

Over reliance on analgesia and displaying aggression in the form of intolerance, impatience, irritability and crankiness towards family/colleagues were amongst the behavioural reactions expressed by the MWAs. These findings were consistent with Moustaka and Constantinidis (2010) and Donovan et al. (2013). The majority of these behaviours were due to the MWAs' inability to cope adequately with work pressures, including heavy workload. Various studies have described several behavioural consequences due to exposure to occupational stress among health professionals, mainly heavy drinking, use of illicit substances, poor diet and smoking (Pikó 1999; Edwards et al. 2000; Donovan et al. 2013). Although studies have identified these as consequences of stress, it was also suggested that these behaviours, with the exception of aggression, were adopted in an attempt to cope with stress (Thompson et al. 2010). These findings were partially consistent with the current study, specifically in relation to poor diet and drinking sugary refreshments (rather than alcohol). A plausible explanation for this partial consistency was that the MWAs were female and located within a different cultural setting from that of the previous studies. Additionally, it was quite possible that smoking and alcohol consumption were not identified within the present study, simply because of cultural differences, as women could not be publicly identified with such behaviours for fear of being rebuked. Although the MWAs were assured of anonymity and confidentiality, in Nigeria it could be considered disgraceful for women to be engaged in excessive alcohol consumption or smoking. Alternatively, this could be attributed to the MWAs' religious beliefs, as the majority indicated during their interviews that there was a spiritual dimension that was integral to their lives. Thus, the MWAs could have perceived drinking alcohol or smoking as unacceptable and against their religion. The MWAs, instead stated that they relied heavily on analgesia, both as a means of alleviating the physical effects of stress and as a precaution against perceived symptoms, partly due to a lack of knowledge of other relief methods. This reliance on analgesia was compounded by the lack of support from management and senior staff to deal with stressors, including work overload, tiredness or lack of appropriate resources.

The MWAs disclosed their being cranky and snappy at colleagues. Invariably, this was similar to the mood disturbance and irritability described in studies mentioned earlier. For instance, Healy and McKay (2000) identified mood disturbances as an effect of occupational stress. These behaviours also had an effect on family relations as MWAs described snapping at their children at home. Anger and irritability were also noted among nurses in Nigeria (Anyebe et al. 2014; Ladan et al. 2014). This implied a developing trait within Nigerian hospitals and more research is needed to understand this phenomenon.

6.6.3 Physical effects of stress

The findings within this study confirmed that the ways MWAs physically reacted to stress was largely consistent with previous research. The physical outcomes of stress ranged from minor somatic symptoms to those of a more serious nature, such as hypertension (Kelloway et al. 2008). Several studies have highlighted the physical effects of stress on health care workers, and especially nurses (Mackin and Sinclair 1999; Arikan et al. 2007; Wu et al. 2010). Donovan et al. (2013) described this as the physiological response to stress within the work environment. MWAs within this study reported high rates of headaches, body aches and pains, profuse sweating and high blood pressure. Consistent with this present study, Moustaka and Constantinidis (2010) identified several physical illnesses associated with stress, including migraines, hypertension, back and joint pain. This was supported by other studies (Chang et al. 2006). Not surprisingly, the few studies conducted involving nurses in Nigerian hospitals also noted headaches and high blood pressure as symptoms of stress (Mojoyinola 2008; Ladan et al. 2014).

Specifically, the MWAs described back aches and muscle pains in their legs and ankles as physical symptoms of stress. This was associated with a lack of adequate facilities and increased exposure to manual handling, including heavy lifting. Other contributory factors were staff shortages and heavy workloads with limited opportunity to take meal breaks. These physical outcomes of stress were consistent with the few studies that described back injuries or musculoskeletal disorders as consequences of stress (Elfering et

al. 2006; Mojoyinola 2008). This was specifically attributed to patient transfer within the hospital (Waddell and Burton 2001). The issue was compounded for the MWAs due to their lack of opportunity to share workloads with other MWAs, such as support with patient transfer.

Both interventions and developments have reduced the frequency of physical injuries within Western hospitals. This is not surprising, given that the majority of these countries' health sectors were more developed, used sophisticated equipment in transporting patients, had health and safety regulations and staff were trained in relation to manual handling (WHO 2007; HSE 2014). In contrast, MWAs were at continuous risk of physical injuries and pain due to heavy lifting, bending, twisting and other manual handling activities. The lack of manual handling training also contributed to the physical effects experienced by the MWAs.

Additionally, Trinkoff et al. (2006) reported that long working hours could also contribute to body aches and injuries due to the exposure to physical/postural risk factors with insufficient recovery time. This was consistent with the findings regarding working long hours, as discussed earlier. The MWAs also experienced high blood pressure due to occupational stress factors. This was consistent with other studies that described similar health problems among healthcare staff (Stordeur et al. 2001; Chang et al. 2006; Effionm et al. 2007; Anyebe et al. 2014; Ladan et al. 2014).

Some of the MWAs experienced profuse sweating and high body temperature. This was in contrast to previous findings, as no other study reported these effects of stress. Although this was highlighted by a few MWAs, it was significant due to the effects on health and well-being.

6.6.4 Social impact

Finally, the MWAs highlighted the social impact of stress on their life outside work. Specifically, the MWAs described being withdrawn from their family and living a restricted social life due to work stress (see Michie (2002). For

instance, Anyebe et al. (2014) noted that nurses in Nigerian hospitals expressed being withdrawn from their family due to stress. These studies were consistent with the current findings from MWAs. The social impact of stress has also been noted by other studies within the work-life imbalance literature. For instance, nurses in a London mental health trust noted a poor balance of work and home life due to stress experienced at work (Currid 2008). As noted earlier, Akanji (2013) described how the spillover effect of stress on an individual's non-working life caused family conflicts. Consistent with the findings of this current study, the nurses and midwives were primary care givers for family members, including children and spouses (Schluter et al. 2011). In addition to their occupational demands, the MWAs were expected to meet their family needs, including looking after the children and maintaining family relationships. This role (family and work) created a further pressure for the MWAs due to a lack of balance due to competing demands. This often made the MWAs feel helpless and worried as they missed spending quality time with their children and families.

Studies have shown loss of family time and restricted social life resulted from major causes of stress including exhaustion from heavy workload, working long hours and effort and reward imbalance (poor incentives and salaries) (Demerouti et al. 2004; Hammer et al. 2004; Hämmig et al. 2012). Consistent with the current findings, prior research identified long working hours, arriving home too tired and heavy workload as factors that limited the time and energy available for family interactions and leisure (Montgomery et al. 2006; Sprinks 2013). This implied that the MWAs' experience of stress made it difficult to fulfil their family roles effectively. Additionally, it was noted that feeling unable to meet family role obligations due to the extensive time and energy required at work could be a result of occupational stress for healthcare workers (Tone Innstrand et al. 2008). This was attributed to such individuals cognitively searching for solutions to resolve such conflicts while at work. The MWAs expressed persistent dissatisfaction with their poor wages, limited time off work and imbalance in effort and reward (salary), which impacted on their ability to meet family needs. In view of such feelings, the MWAs often thought about ways to improve their current situation but were hindered by lack of opportunities.

Additionally, the MWAs had a restricted social life. This was because the MWAs did not have enough time and were too tired to socialise when off work. Furthermore, the MWAs preferred to spend the little time they had off work recuperating from stress. This contributed to the MWAs having a limited circle of friends. Interestingly, only a few existing studies reported such similar social consequences of stress, restricting their focus to the impact on family relations (Tone Innstrand et al. 2008; Hämmig et al. 2012). Nevertheless, this also impacted on the MWAs' quality of life. Thus, the afore-mentioned studies concluded that the caring professions, including nursing and midwifery, were stressful. This impacted not only on the health and well-being of the staff but on their quality of life, and had a negative effect on family relations. Most especially in the case of women, who constituted a significant proportion of professionals in these disciplines who had to meet the demands of their profession as well as those of their home life (Prowse and Prowse 2015). Though further research is required with non-professionals, it was concluded that nurses and midwives were at greater risk of poor quality of life due to competing demands from home and work. Although the settings and context of existing research differed from that of the current study, the findings and conclusions were consistent, implying that women in the healthcare setting (irrespective of professional status), including MWAs were exposed to similar stressors and were at great risk of poor quality of life and work life balance issues. This risk was greater for the MWAs participating in this study due to the culturally different and disadvantaged working environment.

Furthermore, the MWAs' experience of stress impacted on their ability to make future plans or create opportunities to enhance their employability. This was a novel finding; no other study described similar findings. This could be attributed to the difference in organisational setting and research population. In addition to work stressors, the MWAs also had to contend with external factors, including very heavy traffic, which impacted on the time and energy they expended on travelling to and from work. The managements' lack of commitment to the MWAs' development also limited their chances of making any future career plans. The lack of feedback mechanisms within the maternity setting also impacted on the MWAs ability to assess their level of performance

to determine areas of improvement if required. This hindered the MWAs in making appropriate plans to improve their career prospects. By contrast, despite lack of feedback being identified as a stressor in previous studies, it was not reported as having an impact on nurses' future plans (Moustaka and Constantinidis 2010).

In developed countries, including the UK, various discussions have occurred among researchers and policy makers on promoting work life balance through different initiatives, such as flexible working (Edwards and Robinson 2004; Fleetwood 2007). Despite criticisms of flexible working in terms of discrimination and contradictory effects, including from full-time staff who feel excluded from work life balance (WLB) and have often been used to cover the gaps at work, this has had its benefits (Roberts 2007; Prowse and Prowse 2015). For instance, flexible working was an approach suggested in the UK maternity service to deal with staff shortage and improve midwives' health and well-being (Kennedy et al. 2010). A similar approach could be adopted to reduce the shortage of MWAs in Nigeria. In contrast, as stated earlier, the MWAs in Nigeria worked full-time with no option of flexible working. This was a contributory factor to loss of family time and restricted social life.

6.7 Coping mechanisms and support available

The fourth main area explored within this study was the coping mechanisms and support available to the MWAs within the maternity setting. Previous sections of this chapter discussed the various sources of stress and the impact this had on the health, well-being and social life of the MWAs. Despite these stressors and their detrimental impact, the MWAs lacked support from the management and adopted different tactics to cope with stress at work. Keeping stress to themselves or self-supporting/pretending to cope and sharing work stress with colleagues, family members and a few senior staff were the main mechanisms adopted by the MWAs. Other day-to-day practical tactics practiced by the MWAs included prioritising workload, taking casual breaks, taking sugary refreshment and using religious faith. However, the majority of the MWAs relied mainly on painkillers to alleviate the overall daily

physical strain. The majority of these coping mechanisms were maladaptive as they were also behavioural reactions that also impacted on the MWAs' health and well-being. This generally implied that, although the MWAs identified different mechanisms, the findings demonstrated that the MWAs were not coping with stress. This confirmed Lazarus and Folkman's (1984) proposition that coping is a behavioural effort to manage or tolerate events that an individual perceives as threatening to their health and well-being.

Similar to the current findings, previous research found that healthcare staff, including nurses and midwives, adopted a range of coping styles (Lazarus and Folkman 1984; Lee 2003; Lambert et al. 2004; Chang et al. 2006; Mark and Smith 2012). These were either problem-focused mechanisms that eliminated or reduced work stressors, or emotion-focused approaches that often blocked the perception that a stressor was occurring (Payne 2001; Flanagan and Flanagan 2002; Chang et al. 2007; Button 2008). However, some daily tactics employed by the MWAs, including taking casual breaks and drinking sugary drinks, were not reported in such studies. Instead social support was frequently noted as a means of buffering stress among healthcare staff (Jenkins and Elliott 2004; Peters et al. 2012). This was in contrast to the current study, as MWAs lacked such support from senior staff or management and had only a limited access to co-workers. Healy and McKay (2000) commented that a high level of stress was associated with a lack of coping and reduced mental health. This was partially consistent with the findings of this study as the majority of MWAs stated they had no specific means of coping but adopted mechanisms that seemed appropriate at the time. This could also be attributed to a lack of awareness of possible coping strategies or lack of opportunities to engage in stress alleviating activities. Internationally, several studies identified that feeling well supported within a workplace was an important factor in mediating the effects of stress (Bruneau and Ellison 2004; Chang et al. 2007). This further identified that management had an important role to play in communicating their support to the MWAs to minimise the impact of stressors experienced at work.

It was concluded from the findings of this current study that the MWAs were unable to deal effectively with certain stressors, including work overload, and therefore adopted more emotion-focused approaches, including pretending to cope with work demands. This was because some of these issues were out of their control and the MWAs had no confidence that senior staff would support or help them if they attempted to share their stress experiences. Interestingly, McGrath et al. (2003) reported similar findings of nurses using avoidance behaviours or self-control to cope with the demands of their job (see (Lambert et al. 2004; Laranjeira 2012). Chang et al. (2007) described this as postponing the effects of stress, which was harmful to health and was associated with reduced mental health. The literature stated that nurses in particular, adopted both problem-solving and emotion-focused approaches with evidence of benefits of problem-focused coping mechanisms (Li and Lambert 2008; Lim et al. 2010). However, this was not evident among the current study population. The MWAs' lack of appropriate channels or personnel to seek help from with stress also contributed to them pretending to cope. This also resulted in the MWAs sometimes displaying aggression towards colleagues in an attempt to take their stress out on others.

Furthermore, in an effort to alleviate stress, some of the MWAs attempted to share stress issues with their colleagues. Only a few of the MWAs shared them with senior staff with whom they were familiar with and the majority discussed their work stress with family members. Most of the studies conducted identified workplace social support as an effective coping mechanism, including talking to others, getting help and seeking advice within the workplace (Payne 2001; Lee 2003; Hawkins et al. 2007). However, none of these studies described receiving from senior staff. Studies identified that stress counselling facilities/management training or occupational health personnel were available to provide support on stress issues within or outside their workplace (Edwards and Burnard 2003; Cooper 2013). This contrasted with the current findings as the MWAs lacked access to such facilities and relied on speaking with the very few senior staff (midwives) they had a rapport with in the maternity ward.

Lee (2003) identified maintaining social communication as a coping strategy among primary care nurses working in Hong Kong. This was partially consistent with the current findings because the MWAs worked alone on each shift and could only seize limited opportunities to communicate with colleagues during handovers or shift changes. Other occasions presented themselves when the MWAs were on a different ward or met colleagues from other departments in the hospital corridors. The MWAs identified this as the best form of support and coping within the hospital. The hospital did not have a counselling unit or psychologist that the MWAs could be referred to for help. Furthermore, the MWAs believed it was easier to share stress issues with colleagues rather than with senior staff because colleagues shared similar experiences at work and could relate to their problems. Some of the MWAs described feeling slightly relieved when they shared stress experiences with colleagues, a phenomenon consistent with findings in the literature (Tyson et al. 2002). This was described as a stress buffer for nurses in Ontario hospitals (Tyson et al. 2002). Furthermore, strong co-worker support was reported to decrease the level of occupational stress among workers (McCarthy et al. 2010). This could also have contributed to the MWAs' resilience within the maternity settings, as despite facing heavy work stressors, they still were able to do their job. Although the MWAs narrated the impact of such stressors on their health and well-being, they indicated that the aspect of their job which they loved was caring for mothers and babies, even though this was limited. This was similar to Hunter and Warren's (2014) finding among midwives; however, this still needs further research among MWAs. Also a few of the MWAs used humour as a coping strategy where practicable. This included talking to colleagues and 'sharing a laugh' together on work issues. This was consistent with findings among nurses in Zaria (Ladan et al. 2014). This could also be attributed to individual traits used by MWAs to develop resilience, as noted by McDonald et al. (2016). Despite this, the MWAs still lacked the organisational support needed, including awareness of effective coping strategies, team work, recognition and reward, to develop resilience at the level required within their work setting (Ablett 2007; Gillespie et al. 2009; Pipe et al. 2012; Foureur et al. 2013; McDonald et al. 2016).

Most of the MWAs drew on support from their family members outside work to deal with stress. This was the best support mechanism available to the MWAs. This was perceived as a positive coping strategy that helped the MWAs to express themselves better and discuss their stress issues without constraints. The majority of studies on healthcare workers focused on social support within a workplace context. This limited the potential for comparison in this particular aspect. However, family support has been noted as an important means of reducing stress levels among nurses (Laranjeira 2012). The MWAs relied on their family members, and more specifically their husbands, to discuss work stress issues due to poor support networks in the hospital setting. This was in contrast to the majority of existing studies, which reported that seeking social support from the workplace was one of the most common coping strategies employed in the healthcare setting (Healy and McKay 2000; Chang et al. 2007; Li and Lambert 2008; Lim et al. 2010). Also, these findings occurred more in Western cultures, mainly among professionals, than anywhere else. Despite the partial consistency with previous findings on seeking social support, the MWAs did not show any signs of reduction in stress based on the coping mechanisms adopted. This was unlike other studies, which conveyed mixed evidence of the effectiveness of problem solving and emotion focused coping. The MWAs used more of the latter and there was no evidence that they used the former in dealing with stress. This was compounded by their lack of information on stress coping strategies and lack of commitment from the management to support the MWAs.

Attempting to prioritise workload or tasks and taking casual breaks were other tactics employed by MWAs to cope with the effect of stress during their shift. These efforts were often not sustained. Making plans and prioritising workload or task were identified as positive coping strategies (Welbourne et al. 2007). However, this was only feasible if there was sufficient opportunity. Despite this, the MWAs noted that such plans were often not achievable due to staff shortage and constant interruptions. Furthermore, such casual breaks were not recognised or accepted within the maternity ward and this was frowned on by some senior staff.

Additionally, religious coping strategies were a common practice among the MWAs. In Nigeria, religious beliefs and working practices are intermingled; therefore it is not uncommon to appeal God or Allah for help or support. This may not be the case in other countries where society is more secular. This was consistent with Anyebe et al. (2014) and Ladan et al. (2014). Anyebe et al. (2014) described this as an effective method of coping with stress. The religions MWAs practised were mainly Islam and Christianity. These religions offered some advice on using faith to minimise worries or stress. However, the MWAs often lacked adequate time to rest and relied on their faith in God as a positive means to reduce the effects of stress. This was also linked to most Christians sharing the belief that God is sovereign and in control of their lives. From a scriptural perspective, instead of worrying over problems, which further compounded the stress experienced, the Bible advised taking everything to prayer (Bible King James Version 1982, Philippians 4: 6-7). It was against this cultural/spiritual back drop that MWAs explain why they often offered prayers of hope to alleviate stress. In support of this, it was suggested that people with religious beliefs may be able to draw on divine assistance to help them cope with stress that impacts on their health and well-being. This was supported by Harrison et al. (2001). These researchers identified that seeking spiritual support was generally associated with lower rates of depressive symptoms. Consequently religious coping could be associated with a particular cultural context, where the majority of MWAs still practised religion, a perspective not reported in previous studies. However, Chang et al. (2007) described this as wishful thinking or hoping for a miracle, which was an emotional avoidance strategy that should not be encouraged. Instead, occupational stressors should be dealt with at the source. However, spirituality was noted as a strategy to building resilience although this was often associated with developing existential meaning and individual uniqueness or connectedness and occasionally linked to religious belief (Ablett 2007; Jackson et al. 2007).

Despite the mixed evidence on support and coping strategies, arguably a good social support network was key to mediating the effects of stress on health and well-being and a significant strategy to building resilience (Tugade and Fredrickson 2004; Jackson et al. 2007; McAllister and McKinnon 2009).

Additionally, consistent with the current results, different studies found that emphasis should be placed more on problem-focused approaches and staff should move away from emotion-focused strategies (Healy and McKay 2000; Lambert et al. 2004; Chang et al. 2007; Li and Lambert 2008). Chang et al. (2007) argued that to reduce workplace stress, staff should adopt approaches that addressed stressors instead of internalising responses to stress. This was supported by a study which reported that nurses should use more direct action strategies, including being as organised as possible and prioritising attending to important issues (Lee 2003). This was an interesting contrast to other studies. Despite this, these research findings support those of other researchers (Chang et al. 2007). Specifically, that the MWAs' should reduce their tendency to distance themselves from stressors by pretending to cope, self-supporting or taking it out on others and should address workplace issues directly.

Certainly, MWAs addressing such workplace issues and developing the right coping strategies would involve their having the right latitude and the necessary management support to influence a better workplace environment.

The current findings in a cultural context

Culture plays a key role in influencing how people vary in their reactions to stress (Kuo 2011). Thus, it is important to understand the current findings of MWAs' perception of stress from a cultural context. Laungani (1993) suggests that each culture produces unique stressors, as cultures vary not only in their social and physical environment, economic state but also in their values, behaviours and ideology.

Stress is experienced by individuals in modern, complex and developed countries as well as by those in developing societies (Kuo 2011). Hence, individuals manage stress in different ways, often influenced by cultural patterns and religion that evolves in dissimilar ways to deal with different kind of stressors (Hooker 2003). Beehr and Glazer (2001) also noted that culture has the potential to influence different aspects of the stress process because

culture is something intrinsic to both the person and environment. Thus, culture formed part of the environment and potentially influenced which stressors the MWAs experienced and their reactions to them. Hooker (2003) contends that the type of stressors faced in developed countries, including the USA, differs from those in developing countries like Nigeria, with its particular day to day pressures of daily life (for example heavy traffic jams en-route to work, frequent power outage, bureaucratic process and highly unreliable transport systems). These experiences are inherently stressful for individuals in such developing countries. The findings from the current study illustrated the differences in stressors experienced in Nigeria compared to Western cultures. For instance, the MWAs do not have access to intercoms to call doctors or wheelie bins to properly transfer waste from the different hospital floors. Although it was noted that some of the stressors reported in the literature are similar, for example, workload, the cultural component differs. For instance, work overload experienced in Nigeria among MWAs was exacerbated by the lack of adequate infrastructure, work policies and the absence of clear job roles. Furthermore, culture also potentially influenced how the MWAs perceived work stressors and their response to stress including calling on God. Interestingly, there are cultural differences in how sources and effects of stress are described. For instance, MWAs used the phrase 'suffering' which refers to feelings of depression and sometimes anxiety in the Western culture.

Coping with stress is described as a universal phenomenon experienced by individuals from different cultures; however, how the process stressors are appraised to initiate a response varies significantly (Lazarus and Folkman 1984; Beehr and Glazer 2001; Folkman and Moskowitz 2004; Chun et al. 2006). Hence it can be noted that there is an intricate link between culture and reactions to stress (Kuo et al 2006). The findings of the present study affirm the conclusions of Kuo et al (2006) that culture plays a significant part in the choice of coping mechanism. MWAs in this study employed different coping mechanisms including calling on God for help to deal with the effect of stress which contrasts with methods described elsewhere in the literature, but conforms to the Nigerian culture (Anyebe et al. 2014). Studies conducted

within Western cultures often reported that healthcare workers deal or cope with stress by smoking or drinking alcohol, as noted earlier. However, in the Nigerian culture it is openly unacceptable for women to smoke or drink, even with a genuine reason, including alleviating stress. This is one of the reasons why Lam and Zane (2004) argued that it is necessary to conceptualise, as well as have an in-depth understanding of how and why individuals from different cultural backgrounds select their own coping methods. Hence Smith et al (2006) emphasised the need to discern and apply valid cultural constructs to achieve an in-depth insight into how stress is construed across cultures. This implies developing cultural and work specific interventions to alleviate stress among individuals through more effective training in personal development and coping strategies. As Lazarus and Folkman (1984) noted, an individual's coping response is bounded by their cultural norms. The findings of this present study re-affirm this position, laying the foundation for further research that might investigate cultural differences. However, despite the key role culture plays in Lazarus and Folkman's (1984) theory of the stress-coping process, the existing literature can be criticised as being overtly Western, not adequately exploring cultural implications when survey tools are used within cultures such as Nigeria.

The issue of social support discussed by the MWAs contrasted with studies that identified some support provided by managers and supervisors within the healthcare settings (McDonald et al. 2016). The source of support is an important dimension to be considered when evaluating effectiveness in reducing stress and its connection to culture or its appropriateness (Beehr and Glazer 2001). Social support within a Nigerian context, specifically among MWAs, was mainly from co-workers, family members outside work and very little emanated from senior staff or supervisors. In Nigeria, a hierarchy of power dominance of superiors over subordinates exists and often this power is abused without any formal disciplinary action taken. Thus, due to the poor employment conditions and lack of Government legislation to prevent workplace harassment, MWAs do not expect to receive any support from superiors, who do not see the importance or need to support a subordinate.

Moreover Glazer (2006) and Brew and Cairns (2004) argued that senior staff offering support to a subordinate can be construed as preferential treatment, which can cause resentment from co-workers. Offering support may also reflect badly on the supervisor, as it may be assumed that his or her subordinate is unproductive. This is a possible explanation for the MWAs not receiving support. However, the researcher was inclined to believe that the hierarchical power culture prevalent in Nigeria, where superiors would far prefer to exert power over a subordinate than offer support accounts for this. Hence, the cultural context within this study determined in part what type of support the MWAs could access and its effectiveness.

Cultural comparison

There are clear cultural differences between this study setting and the regions widely reported in the stress and coping literature (Kirkcaldy and Martin 2000; Payne 2001; Lee and Wang 2002; Garrosa et al. 2008; Li and Lambert 2008; Peters et al. 2013). Staff shortage, organisational constraints and workload are consistent cross cultural occurrence. This study demonstrated that their context differs however, according to the constituent parts of the workload.

Despite similarities, there are notable differences in findings between developing regions and the developed Western world. For staff in the developed cultures, lack of autonomy and role conflict contributed to stress. This however, differed from the non-Western culture, for although staff experience interpersonal conflict, within this culture they are often subjected to verbal abuse and power exploitation from their superiors. This form of exploitation is rarely reported in developed countries and in part this can be attributed to Government legislation to ensure workplace harassment is reduced. Yet there is no such safeguard in developing countries including Nigeria. Hence, the subordinate staff are subjected to constant unfair treatment including verbal abuse from senior staff without any right of redress (Oku et al. 2014).

Another marked cultural difference concerns infrastructure. Most studies in the Western or developed countries do not report lack of equipment as a stress

factor in contrast, this was a major stressor in the present study and is supported by published research from the same region (Lasebikan and Oyetunde 2012; Mojoyinola 2008; Ladan et al. 2014). Hospitals in developing countries lack adequate facilitates and often rely on outdated equipment or manual manoeuvring to carry out tasks. This can be attributed to the shortage of supplies and poor funding in developing countries however, in Nigeria this is exacerbated by lack of accountability, mismanagement, abuse of power and misappropriation of funds that bedevil the healthcare system (AHWO 2008; Majekodunmi and Awosika 2013).

Furthermore, a notable difference relates to the issue of death and dying as a major stressor among staff in Western cultures that was not apparent in the present study. This difference may be attributed to individual's resilience in developing countries mainly because there are not many counselling facilities to support staff who witness the death or who care for dying patients. In most cases, it might be viewed culturally in Nigeria by management as another unfortunate but predictable occurrence, which senior staff do not actively seek to provide support for those in their charge.

Finally, although the issue of working long hours was noted as a general stressor, 12 hours was reported as the longest-permitted shift in the Western culture however, staff in developing countries work longer hours (Lasebikan and Oyetunde 2012). The MWAs in the present study work 16 hours as a normal night shift. The occurrence of such long shifts is due to an absence of safe working regulations. Compared to the Western countries were staff are sometimes compensated either with overtime pay or time off, such options are not available for health care staff in developing countries. They are frequently accused of either being lazy or with dismissal if they challenge the *status quo.*

The use of survey techniques must be employed expressly with these cultural considerations in mind. This means that few tools can be used reliably and discrimination is required to be certain that they are appropriate to the cultural setting in which they are to be deployed.

6.8 Excerpts from my reflective diary: Findings and discussions

I am not sure how the findings will be received by the hospital management. I noticed there was a significant difference in how MWAs described their sources of stress and what constituted this. Workload was often described in terms of work overload as MWAs were involved in long hours and more physical and heavy duties compared to the Western settings where heavy administrative workloads were often the issue. However, staff shortage was a consistent issue.

I observed that the term management is used to refer to 'leadership' which is in contrast to Western countries. The Western concept of leadership does not seem to exist in the maternity setting.

6.9 Discussion summary

In summary, the current findings support existing studies in terms of the main occupational stressors to a very large extent. Specifically, the majority of studies reviewed highlighted excessive and heavy workload as the major stressors among healthcare workers, including midwives in the hospital setting (Healy and McKay 2000; Lee 2003; Lambert et al. 2004; Chang et al. 2006; Sveinsdóttir et al. 2006; Weyers et al. 2006). It can be inferred that, as nurses were under continuous pressure to do more, the MWAs in Nigeria were exposed to similar, if not more stressors, as a result of their unique working conditions. Nevertheless, the workload issue was exacerbated for MWAs due to exposure to unfavourable working conditions, including manual handling challenges and lack of appropriate equipment. Other similar and consistent stressors were identified within the literature, including a lack of decision-making opportunities and difficult interpersonal relationships (French et al. 2000; Lee 2003; Sveinsdóttir et al. 2006; Arikan et al. 2007; Mojoyinola 2008; Nyssen and Hansez 2008). The issue of working long hours was also partially consistent with previous studies including Geiger-Brown et al. (2004), Arikan et al. (2007) and Keller (2009). However, the MWAs worked a 16-hour official shift. This was in contrast to studies that mainly described long working hours in the context of 12 hour shifts. It can be inferred that, the MWAs were more

exposed to occupational stressors due to the longer hours of working than staff noted in previous studies.

The MWAs' level of education and status in the hierarchy also resonated throughout the findings as underpinning some of the reported stressors, including lack of respect from senior staff. This was less prominent among the studies reviewed that involved doctors, nurses and midwives, compared to other stressors. However, these roles could not be compared to the MWAs. Nevertheless, Pikó (1999) noted that nurses with higher degrees reported lower levels of stress than those with primary level education. The latter group experienced the most humiliating working conditions and received the least respect, while the former benefited from the prestige accorded to their higher level of education. This supported the findings of this study, as MWAs generally had a lower level of education, which led to them experiencing discrimination and a lack of respect from senior staff. This confirmed that lower levels of education could form an occupational stressor. Additionally, in contrast to their UK counterparts, the MWAs lacked opportunities to improve their qualifications, which hindered their chances of gaining higher education.

The MWAs also reported environmental factors including exposure to infection, working in hazardous conditions and an unfit MWAs' base as contributors to stress. This was partially supported by previous studies where despite the partial consistencies in findings, caution was exercised due to the differences in setting and severity of these factors within the current study (Stordeur et al. 2001; McGrath et al. 2003; Long et al. 2014). Regrettably, the MWAs appeared to be in worse situations compared to staff in the previous studies, including in terms of working without PPE against infection. This was exacerbated by a lack of care and support from management, policies ensuring health and well-being and regulations regarding physical working conditions within the hospitals.

Finally, human resource factors, including poor salary and lack of career progression, were also described as stressors within the maternity setting. Unlike previous studies, the current research reported discrimination and political decision-making in recruitment and career progression. Compounding

this was the MWAs' lack of voice and irregularities in management processes. This discrepancy was due to differences in organisation of work and variation in recruitment procedures compared to the settings of previous studies.

Taking the above findings into consideration, it was concluded that the MWAs experienced an extremely high level of stress compared to staff in previously reported studies. This study also confirmed that the maternity unit was a busy and challenging setting within the hospital. The MWAs were very clear in expressing their stress experiences and the various aspects that contributed to this, including the perceived lack of care from management. The MWAs generally had no control over their job and continued to work hard in the face of difficult working conditions. Furthermore, the MWAs' stress was, in part, due to their invisibleness and lack of rights, power or voice to shape their working lives. Hence, the MWAs' experience of stress was construed as being less positive and as one that reflected negative views about the organisation, work environment and role. Despite this, there was an inferred low turnover among the MWAs. This was in contrast to previous studies, including Nabirye et al. (2011).

Additionally, several studies highlighted various effects of occupational stress that were consistent with the findings of this study (Gardner 1999; Payne 2001; McVicar 2003). This implied that irrespective of location, individual factors, culture or occupation, the impact of stress was universal. Furthermore, reports have continued to identify the maternity setting generally as a stressful environment, providing a round the clock service on a daily basis (RCM 2014; RCM 2016b) .

Furthermore, the coping mechanisms adopted lent some support to previous studies, specifically in the area of social support and its importance in reducing stress levels. While it was maintained within the literature that the availability of others to care and help was key in mediating the impact of stress on health at work, the MWAs had very limited access to such opportunities. The MWAs relied mainly on a few available colleagues and familiar midwives they could talk to about stress. Although the MWAs had very limited support from co-workers, mainly due to staff shortage, the current findings were partially

consistent with some studies. These studies reported that a higher level of social support from co-workers was related to lower levels of emotional exhaustion (Jenkins and Elliott 2004; Shen et al. 2005). Although emotional exhaustion was not measured, this was inferred from the MWAs discussion on the relief they felt when they shared their stress issues with colleagues. Limited support was also linked to increased susceptibility to poor psychological health (Bradley and Cartwright 2002; Button 2008). Other tactics employed by MWAs on a day-to-day basis included taking casual breaks, drinking sugary refreshment and using religious faith. These measures provided temporary relief in order to deal with immediate stress so as to be able to carry on with work but did not relieve the longer term impact of stress. It could be argued that this also contributed to behavioural reactions to stress, including snapping at colleagues.

Despite the variety of methodological approaches adopted in the afore-mentioned studies, similar findings were reported within the current study. This reinforced the belief that stress is a universal, international problem affecting the healthcare sector. This implied that no group of healthcare staff, specifically MWAs, should be omitted from key interventions developed to alleviate stress. Thus maintaining the health and well-being of MWAs was essential to ensuring a healthy and productive maternity workforce.

Finally, adopting a qualitative methodology for this study instead of a rigid quantitative design made it possible to reveal the unique experiences of stress among MWAs. It provided a qualitative perspective concerning factors that caused stress. It brought to light the sometimes invisible aspects of what constituted MWAs' experiences of stress. The findings, therefore largely supported prior research on stress within the health setting, and provided deeper insight into and a rich description of the MWAs' perceptions. It also provided detailed information about stress within the maternity setting in Nigerian hospitals. The distinctions made in the study between MWAs and other health staff, and between the maternity setting and hospitals as a whole in Nigeria, have not been explored in previous studies. Therefore, comparison of the findings from this study could not be fully achieved. Despite this, the

findings of this study lent support to the methodological recommendation by Wheeler (1998) and Lambert and Lambert (2001) that more qualitative research to understand the complexity of the meanings and experiences of occupational stress from an individual and cross-cultural perspective is essential.

CHAPTER 7 CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

This chapter presents the conclusions to the research study, drawing together the outcomes of the different chapters and the findings generated from the Maternity Ward Attendants' (MWAs) interviews.

Before proceeding with the conclusion, a brief summary of the previous chapters is presented. Chapters one and two introduced the study and the relevant background to Nigeria, its health service provision and the region where this research was conducted. The research questions, aim and objectives, the significance and the conceptual framework for this study were also included in Chapter one. This was followed by the literature review that examined the meaning of occupational stress and relevant theories/models and sources of stress, including work intensification. The effects of stress on an individual's health and well-being, and coping mechanisms adopted by a range of health practitioners, were also reviewed and presented in Chapter three. The methodology, research method, philosophical underpinning, approach to data collection and analysis, ethical consideration and matters concerning validity within this study were explored in Chapter four. The study's findings and discussion of these findings were presented in Chapter five and Chapter six respectively. This chapter provides a conclusive summary to the research questions presented in Chapter one. In addition, this chapter will present the new knowledge derived from undertaking this study and discuss how this may help to fill the gaps within the body of research on stress and coping within maternity settings. The researcher's recommendations to minimise the impact of and help alleviate occupational stress among MWAs and areas for future research are also discussed. This chapter concludes with the strengths and limitations of this study, including a reflection on the author's PhD journey.

This study adopted a phenomenological approach to exploring Nigerian MWAs' perceptions of occupational stress. This approach was appropriate as it enabled the researcher to highlight individual MWAs' experiences and views

on the issues being explored, by capturing participants' perceptions on subjects, about which previously little was known. The findings from this study provide new insight into the MWAs' perceptions of occupational stress, its impact and the coping mechanisms they adopted within the maternity settings.

This study was conducted with approval at three government hospitals in Nigeria that met the inclusion criteria (see Section 4.6.1). Maternity Ward Attendants from these three hospitals participated in individual interviews and provided rich contextual data regarding their perceptions of stress, sources of stress and the impact this had on their health and well-being. Additionally, the interviews generated data on the coping mechanisms adopted by the MWAs and the type of support available, as well as highlighting the absence of support.

The literature review revealed that prior to this study there had been limited quantitative and qualitative studies on occupational stress conducted in Nigeria or other African countries, and none focusing on the maternity settings or MWAs (Mojoyinola 2008; Nabirye et al. 2011; Ladan et al. 2014). This exposed a gap in understanding, thus highlighting the need for further exploration. This study provided an insight into occupational stress and explored the sources of stress among MWAs in Nigeria. The findings created a platform for recommendations that are designed to promote effective stress management procedures and interventions, to minimise or help to alleviate stress among MWAs. It is hoped that the implementation of these recommendations will help to improve the MWAs' experiences of working within maternity settings in hospitals and enhance their health and well-being.

Before presenting the conclusions, the aim and objectives are revisited. These are detailed below, followed by a summary of the key findings for each objective.

The aim of the study was to explore the MWAs' perceptions of occupational stress, possible cause(s), the impact and support available and the coping methods they adopted within hospital maternity care settings in Nigeria. To address this, the following objectives were developed:

1. To explore the lived experiences of occupational stress among MWA's working within hospital maternity settings.
2. To identify the factors that contribute to MWAs' occupational stress.
3. To explore the impact of occupational stress from a MWA's perspective.
4. To analyse the coping mechanisms employed by the MWAs and examine the available support systems for the MWAs (if any).
5. To make recommendations to support the alleviation of stress.

7.1. Experiences of and sources of occupational stress among Maternity Ward Attendants

The first objective focused on gaining a descriptive account of the lived experiences of occupational stress among MWA's working within the hospital (maternity) settings. Biographic data was also collected to provide some contextual information of the study participants (MWAs). Objective two identified the factors that contributed to occupational stress among MWAs. The key findings from these objectives are summarised below.

All the MWAs were familiar with the word 'stress' and what this meant for them within the maternity setting. The MWAs worked on maternity wards that were constantly busy, with limited opportunities to take breaks during their shift. Moreover, the MWAs were able to describe when they felt stressed, by giving detailed accounts of their responses to stress, which included both their physical and emotional reactions. Overall, MWAs who participated in the study experienced symptoms of stress on almost every shift due to the enormous amount of tasks they had to complete and because they felt unable to take time off work when stressed.

The MWAs seized brief moments to discuss stress with their peers and this helped them to define and understand stress. The majority of the MWAs described various stressful experiences and the impact on their health, well-being and social lives. The findings were similar to those in quantitative studies that formed part of the literature review that identified high levels of stress

among healthcare staff, including nurses and midwives (Payne 2001; Peters et al. 2013).

The MWAs felt that they were not recognised or valued, which made them feel like an invisible workforce within the hospital (WHO 2006). In most cases, the MWAs were unable to express or share their stress experiences other than with their immediate MWA colleagues or family. As a consequence of feeling as though they were an invisible workforce, the majority of the MWAs were dissatisfied, which often led to poor morale and discontentment with their work environment. Other factors that contributed to the MWAs feeling invisible were the lack of support from managers when they raised health or work concerns, being excluded from decision making, limited control over their work, accused of insubordination and as a group of healthcare workers feeling that they were considered by the senior staff to be 'the lowest of the low'.

The MWAs identified various factors that caused stress within the maternity settings. Five key themes emerged from the field work and these were further refined through analysis to identify subthemes (Chapter 6). Across all themes and subthemes, the most common occupational stressors were staff shortages, long working hours, work overload, a shortage of resources, lack of adequate support, poor salaries and lack of respect from senior staff. These primary stressors played a contributory role in the emergence of other stressors. For instance, the shortage of resources led to the MWAs being exposed to potential/possible infection and hazardous working environments. This suggests that the stressors were interwoven and could, in certain circumstances, compound the situation by causing maximum stress. In some cases the stressors identified were consistent with the findings of other research studies involving healthcare staff, including nurses and midwives; for instance their role being expanded over time as they took on more work (Healy and McKay 2000; Li and Lambert 2008; Prowse and Prowse 2008).

In reality, on a day to day basis the MWAs' job comprised mainly of domestic duties, which often took them away from their primary task of supporting the midwives in providing optimal care to the mothers and babies. In practice, they were engaged in tasks that were not originally part of their duties but had

become part of the MWA role due to staff shortages in other departments, for example collecting patients' plates and running personal errands (Prowse and Prowse 2008). The findings of this study revealed that, in addition to poor physical working environments, the MWAs had to endure a consistently excessive workload. This caused an enormous pressure and strain on the MWAs, which often led to physical and emotional exhaustion. This contributed to the MWAs feeling helpless and depressed and was further exacerbated by their lack of control over the work stressors.

The work of the MWAs was further worsened by poorly designed shift patterns. The MWAs frequently had to work beyond their official hours, sometimes exceeding the scheduled 16-hour night shift. The shift patterns were rigid and there was no opportunity for MWAs to work flexibly. The combination of these job characteristics contributed to the MWAs' increased exposure to stress, which had an adverse effect on their health and well-being.

The findings of this study also revealed that unclear job descriptions and a lack of consultation in relation to changes to duties had the potential to result in incremental changes to the MWAs' role which over time resulted in significant changes. Consequently, the lack of role clarity resulted in MWAs being subjected to increased work demands and high performance expectations from managers and senior staff. The ambiguous role expectations, along with a lack of clear administrative policies or processes, had a significant effect on the MWAs' approach to functioning and undertaking tasks at work. As stated previously, the MWAs' role has been eroded, and additional tasks were allocated to them without any formal consultation or formal role redesign. Indeed no training was provided for the new tasks and these were added on an ad hoc basis without proper consideration of the impact on MWAs health and well-being. The MWAs were unable to refuse duties even if they were not originally part of their role, causing them to experience work related stress. This was captured during the discussion relating to work intensification within the maternity setting (Chapter 3), which contributed to the risk of physical and mental ill health among the MWAs (Zeytinoglu et al. 2007; Franke 2015).

The MWAs worked in physically and emotionally challenging work environments. The MWAs described working in a hazardous environment with broken tools, lack of access to personal protective equipment and without an appropriate designated staff rest room (MWAs' base). For instance, the MWAs' used a storage room which lacked a fan as a rest area, thus exposing them to high temperatures during the rare occasions when they were permitted to take a break (if permitted at all). The physical work environment was a major cause of stress to the MWAs, which they argued aggravated some of their major stress symptoms, such as physical aches and pains, including headaches. The findings of this study also revealed the emotionally tense work environment within the maternity setting. The MWAs often felt exploited by senior staff, such as the midwives and doctors, for whom there were seemingly no consequences, including disciplinary action. Instead the MWAs were reprimanded or advised to leave their job if they complained about any exploitative behaviours. Maternity Ward Attendants focused on the job in hand and tried to avoid situations which may give rise to their being chastised by the senior staff for doing something wrong. They avoided expressing concerns about their work issues for fear of negative repercussions. The MWAs found it difficult to discuss experiences that gave rise to stress due to their fear of the unhelpful responses from senior staff, except in the few situations when they worked with certain midwives with whom they had good working relationships.

A major factor that contributed to the poor emotional working conditions was the lack of professional working relationships between MWAs and senior staff or managers. These situations created a stressful and unprofessional working environment for the MWAs.

The issue of the lack of career development opportunities was also highlighted by the MWAs. The hospitals did not have staff development plans and there was no provision for job orientation, induction training or role specific training to support the MWAs. The findings of this study revealed that the MWAs did not have access to opportunities for development at either a professional or personal level. This was stressful for the MWAs, who felt they lacked training opportunities to increase their knowledge of the maternity service or equip

them with the skills necessary to perform their duties effectively and improve performance within their role. There was no protocol to set objectives and assess performance at work, thus compounding the lack of clarity around the MWA role.

The MWAs also reported that they felt let down by the managers and some suggested that they (managers) neglected their responsibilities towards them. The health and well-being of MWAs was not given appropriate attention, as the MWAs' pleas for a better working environment were often disregarded by managers. This was a cause of concern for the MWAs, who had to continue working despite the hardships they experienced in their work setting. The MWAs were not allowed to participate in key decision-making processes that impacted on their role and therefore felt that they lacked the opportunity to make creative or entrepreneurial contributions.

7.2 The impact of occupational stress on Maternity Ward Attendants and coping mechanism adopted

Objective three of this study explored the impact of occupational stress from a MWA's perspective, while objective four analysed the coping mechanisms employed by the MWAs and examined the available support systems (if any). The purpose of these objectives was to explore the impact stress had on the MWAs' health and well-being. Additionally, this was to establish how the MWAs coped with stress and what methods were used to deal with the factors causing stress. The objective also included an exploration of the support offered to MWAs by their managers and the hospital. The findings of these objectives will be jointly presented below.

The MWAs exhibited various responses to the experience of occupational stress which impacted on their health and well-being in diverse ways. According to the MWAs', stress impacted on various aspects of their lives, including their physical, emotional, psychological and social lives. These formed the four sub themes identified within this area of the study. Embedded within these themes were significant symptoms of stress, including feelings of

suffering and helplessness and being undervalued, resulting in 'cranky' behaviour or irritability and the lack of a work life balance, resulting in an anti-social life style. The impact of stress on aspects of the MWAs' well-being also had an effect on other areas. For instance, the physical impact of stress resulted in physical aches and pains, which led to an over-reliance on analgesia (behavioural impact) among MWAs. Furthermore, feelings of exhaustion and tiredness often made the MWAs withdraw from their family and live an anti-social lifestyle. The accumulation of all these stressors frustrated the MWAs and caused them to experience very low self-esteem due to their inability to control their work situations.

The findings in this study confirmed there was a lack of formal or informal support for the MWAs from the managers. They relied on the very limited support that came from the few midwives they had a rapport with and on the rare occasion when they could gain co-worker support. The main support systems for the MWAs were their families and themselves. Although the MWAs identified various coping mechanisms they used to alleviate stress, including drinking sugary refreshments, these were mostly of short term benefit. The MWAs identified day-to-day tactics used to cope with stress, including taking casual breaks. However, the evidence provided suggests that, despite the mentioned mechanisms, the MWAs were not coping but just getting by with stress at work.

7.2.1 Summary

In summary, the MWAs felt stuck in their role. There was no opportunity for career progression or training to enhance their employability outside the maternity setting. This lack of career progression and support from the managers contributed to the MWAs feeling undervalued, unrecognised and an invisible workforce within the maternity setting. The emotional impact of stress led to feelings of depression and frustration, resulting in the MWAs being unable to improve their chances of either getting a better job or advancing at work. The MWAs' role was marginalised and MWAs' managers did not consider or include them when deliberating over improvement strategies. This arguably challenged every aspect of the MWAs' role and their sense of self-

worth and control, resulting in the stress they experienced. From the MWAs' accounts, the perception that aspects of their work were 'invisible' meant the MWA role was not fully understood, leading to unrealistic expectations and exploitation by managers, midwives and other healthcare professionals.

From these findings, it can be concluded that MWAs in this study faced similar stressors to those of healthcare staff working in other countries but that as this research study has shown the stressors were exacerbated.

7.3 Recommendations

The following recommendations are based on the findings from this study and include suggestions from the participating MWAs. The recommendations were formulated with a specific emphasis on interventions to minimise/alleviate stress, coupled with strategies to build resilience and to improve MWAs' health and well-being, and experience of work. Consideration is also given to the feasibility of implementation and resources required. Additionally, these recommendations have the potential to contribute to meeting the Sustainable Development Goal (SDG) 3 of the United Nations (UN) 2030 agenda. A combination of recommendations, focusing on both the MWA role and on work environment/organisational (hospital) factors, are detailed below. Policy recommendations are also highlighted, including possible implementation issues. The recommendations are clustered into themes in relation to the findings of the study as follows: Maternity Ward Attendant experience of work, physical resources and estate issues, local policies and improve MWAs' coping mechanisms and access to support to enhance resilience.

7.3.1 Maternity Ward Attendants experiences of work

The findings suggest that managers and hospital employers need to be well-informed about occupational stressors and its effects within their organisation. Hence, MWAs may benefit from swift action being taken in relation to some of the recommendations outlined below.

There are various recommendations proposed for improving the experiences of MWAs and alleviating occupational stress. Based on Lazarus and

Folkman's transactional theory of stress (1984), occupational stress can be managed at three levels: primary (prevention), secondary (timely reaction) and tertiary (rehabilitation). This multiple level approach could be adopted to enhance the MWAs' experiences of working within the maternity setting. Recommendations with significant resources required will be secondary to those which are more realistically achievable in the interim.

Recommendations:

1. Develop a clearly defined MWA role description: This can be achieved by analysing the MWAs' role and redesigning it to include the development of a detailed job specification. The qualifications, skills and attributes required for the role should be clearly articulated. Clear process for amending job descriptions together with regular review of roles would guard against role 'creep'.
2. When scheduling the work rota/shifts (roster), consideration should be given to increasing the frequency of the MWAs' off duty time, incorporating formal and recognised meal breaks into the shift pattern as this will ensure MWAs have a recognised scheduled break during a shift, reduce the hours worked on night shifts and embrace flexible working.

   Rationale:

   These proposals will contribute to the management of expectations in relation to the MWA's role and provide a clear start and end of shift, with the potential for reducing work intensification within the maternity ward. The measures will also assist in improving the MWAs' social life by increasing the time available to spend with family members.

3. Resolving workload issues:
   a. Hospitals should review staffing establishment to guard against the work overload described by the MWAs.
   b. Reduce the unnecessary workload associated with the MWAs' role. This could be achieved, in part, by a clear job description,

removing duties that were not originally part of the MWAs' role and are considered to be inappropriate. This may mean re-allocating such responsibilities to the relevant departments. For instance, re-allocating domestic duties to the kitchen staff and re-allocating collection of blood bags to laboratory attendants.

Rationale:

This set of recommendations are intended to reduce the burden of work on the MWAs work overload and free up time to effectively accomplish tasks to the required standard and protect meal breaks. These interventions will also help to re-focus the role of the MWAs on supporting the midwives in offering optimal care to mothers and babies.

4. The hospital should ensure a supportive working atmosphere is created for the MWAs, where they feel respected and are able to bring concerns to the attention of management for resolution without fear of being insulted. This could be achieved by ensuring the MWAs feel encouraged, accepted and appreciated by senior management. Additionally, a recognition and reward scheme should be developed to reflect the MWA's valuable contribution.
5. The MWAs should be included in decision-making processes. This should include consultation in relation to their role or organisational changes. Hospital management should consider MWA representation within the overall governance structure.

Rationale:

These measures will promote transparency in decision-making and enhance management's openness with staff. This will potentially increase the MWAs sense of self-worth and make them feel like an integral part of the maternity workforce, by giving the MWAs the recognition and voice at work they desire. This process also has the potential to improve effective communication among the MWAs and senior staff, boost the MWAs' trust in their employers and reinforce their (employers') commitment to health and well-being.

7.3.2 Physical resources and estate issues

1. Improving the physical work environment and promoting a healthy living:
    a. Making appropriate workplace adjustments, including the adequate provision of a MWA's rest area (work base) that is equipped with the required facilities, such as a fridge and air conditioning. Workplace adjustment can be achieved by creating a different storage room and refurnishing the current MWAs' base to make it more conducive for rest breaks.
    b. Consider ergonomic training for staff to ensure a safe workplace and reduce injuries sustained among the MWAs. For instance, providing training on how to lift heavy items, if such tasks cannot be eliminated.
    c. Ensure an adequate supply of the required resources, including vaccinations and personal protective equipment (gloves).
    d. Invest in effective equipment, such as durable wheel chairs and patient transfer infrastructure, including a lift system and trolleys for moving objects, introduce a telecoms system to call doctors during emergencies instead of MWAs having to respond by physically searching for medical staff to assist with emergency situations.

Rationale

These recommendations will ensure adequate protection, reduce MWAs exposure to infections within the maternity ward and the physical impact of working with poor equipment.

7.3.3 Local policies.

The hospital management should:

1. make available and encourage MWAs to undertake specific/targeted training that will equip them to fulfil their roles to the highest standard and improve their chances of career progression within maternity services.

2. introduce policies to manage workplace harassment and bullying, including a complaint handling procedure. At the same time, they should create and display an anti-discrimination policy in the hospital to promote awareness among staff. This should include a practical approach to resolving conflict among staff.
3. ensure the concept and practice of universal safety precautions are promoted within the hospitals and implemented by MWAs.
4. ensure appropriate systems are implemented and evaluated to manage health and safety issues.
5. explore the possibility of employing an occupational health practitioner to offer counselling sessions (if required).
6. implement a recognition and reward scheme that include MWAs.
7. Training and awareness:
    a. Hospital management should:
        I. increase awareness among MWAs and senior staff of sources and potential effects of stress on the MWAs' health and well-being
        II. increase awareness among senior staff of their responsibilities to promote and ensure the well-being and safety of employees.
        III. train senior staff to recognise and support MWAs showing signs of occupational stress.
    b. Training programmes should be available to encourage team working within the maternity setting, irrespective of professional status.
    c. Senior staff should be trained in two-way communication and made aware of what should be expected from the MWA role. This improved communication process and level of expectation should also include other departments and units within the hospital.

Rationale

This next set of recommendations are aimed at creating a conducive working environment and enhance the senior staff's ability to provide

support to the MWAs. Furthermore, this has the potential to increase MWAs' morale, improve their workplace safety, and make them feel more rewarded and valued in their work environment.

7.4 Improve Maternity Ward Attendants' coping mechanisms and access to support

1. Hospital should ensure the MWAs have access to support from senior staff and encourage positive thinking to enhance coping strategies. An approach could be to develop a good support system or network to provide interventions to ensure MWAs cope with stress.
2. The MWAs should be trained or supported to develop basic stress reduction skills, including engaging in physical exercise, time management, and effective prioritisation of duties. Hospital management should create opportunities to ensure the MWAs can access such stress management courses or training.
3. Develop and foster a supportive work environment for the MWAs. This is aimed at ensuring MWAs build supportive relationships or networks to develop resilience.

Rationale

These recommendations could have a positive impact on the support available to MWAs at an organisational level and encourage them to utilise problem-focused coping strategies. The effectiveness in coping with stress will potentially enhance the MWAs competence and confidence in handling workplace issues, increase the frequency of positive emotions and attitudes and their commitment to work. In general, these recommendations, if implemented, will promote the development of resilience among MWAs, transform work culture, increase employee satisfaction and improve health and well-being.

Possible implementation issues

1. Inadequate funding and the current economic situation in Nigeria challenges the recruitment of the required workforce, including MWAs.

2. The lack of an adequate pool of skilled personnel, including occupational health nurses or health and safety personnel to undertake required evaluations and assessments, challenges the development of much required training and workshops.
3. The hospital environment culture may inhibit the recommendation due to the following:
    a. The current MWAs' workload, organisational practices and staff shortages limits the opportunity for individuals to engage in stress reduction activities (if available).
    b. The need for institutional level commitment to changing the culture and employment practices may be challenging.
    c. Senior staff commitment to locating the MWA role as a fundamental part of the maternity team.
    d. Lack of national legislation and policy concerning discrimination.
4. Inadequate legislation against anti-discrimination and poor enforcement of current (inadequate) occupational health and safety (OSH) legislation in Nigeria challenges implementation.
    a. Lack of adequate penalties for violating OSH laws.
5. Lack of governmental commitment to health, safety and well-being.

Despite this, not all the recommendations have financial implications, thus the hospital could decide whether to prioritise the health and well-being of the MWAs.

In summary, these findings and recommendations can be used to develop broader management interventions to alleviate stress. Reducing the symptoms of physical and psychological ill-health, will improve the health and well-being of the MWAs and increase their commitment to work, their job satisfaction and also enhance patient safety. The implementation has the potential to improve the quality of maternal care delivered to mothers and babies. Furthermore, managers and senior staff will be more aware of their health safety and well-being responsibilities. These interventions could lead to a healthier and more productive work environment, that in turn could be emulated by other hospitals and increase the international profile of Nigerian maternity care.

7.5 Research contribution

An enormous amount of research on occupational stress has focused on professional healthcare workers other than MWAs. This deficit in the literature was a major catalyst for the choice of this study. Additionally, the majority of literature available in the field of occupational stress has been undertaken using a quantitative approach. This failed to fully explore participants' individual understanding and perceptions of stress, in order to capture their lived experiences before attempting to measure levels of exposure. This study was able to address the absence of such qualitative data.

The unique contribution this thesis makes is that it provides a detailed insight into the working life of Nigerian MWAs, their experience of stress and the coping methods they adopt to manage or contain it. Also it illuminated the current practices within Nigerian hospitals, specifically the maternity service. The findings from the thesis provides a picture of the sometimes harsh realities of MWAs' working life. At the same time, the MWAs' role is ameliorated as a consequence of the satisfaction derived from working with mothers and babies.

Undoubtedly work intensification and role expansion are predominate factors that caused MWAs' stress and contributed to the ill-health and poor work-life balance they experienced. This is compounded by the absence of support or understanding of the MWAs' role by both managers and many midwives; MWAs are told to 'just get on with it'. Although there are some parallels with MSWs in the UK, these workers have legislation to protect them. In Nigeria, although MWA's provide an invaluable service in maternity care, they are relegated to an almost 'invisible workforce'. They are excluded from decision-making, and work in poor conditions where their physical and emotional needs are neglected or ignored. The MWAs' low levels of educational attainment was used to explain their exclusion and experience of relegation. Arguably this study has offered ground breaking insights into the organisations attitudes to work and stress in a specific Nigerian workforce (Mojoyinola 2008; Anyebe et al. 2014).

It is important to note that the situation outlined above is not unique to Nigeria and echoes some of the experiences of health care workers globally (Payne 2001; Mollart et al. 2013).

However, the picture that emerges is not all negative; indeed the resilience of the MWAs is apparent in their comments and there are occasions when, as a group, they challenge management. These actions may be embryonic, but reflect the approach taken by other global workers to seize the initiative and take control.

The complexity of Nigeria as a country cannot be ignored and the findings of this thesis need to be considered in relation to this. Nigeria is an evolving nation with many changes occurring, not least of all in health care. The MWAs' role is still being developed and the findings of this study illuminate areas of consideration. MWAs reactions to stress are shaped by cultural parameters which result in quite different norms emerging. These norms were then subsequently found to be re-enforced by the maternity service context explored in the three hospitals.

Arguably, from a methodological perspective, the qualitative nature of this study, and the focus on the MWAs' voices, makes this different from earlier occupational stress research that focused solely on nurses. It is one of the very few studies to adopt interpretivism, using a qualitative methodology and a phenomenological approach to explore occupational stress. This was in contrast to the dominant (quantitative) methodology found throughout the literature reviews (Payne 2001; Peters et al. 2013).

This study has contributed to the existing knowledge on stress and coping but also provided more detailed insight into occupational health, safety and well-being, organisational behaviours and cultures, and human resource management within a Nigerian context.

Thus, this research potentially adds value to the field of occupational stress in the Nigerian context specifically, in Africa and the international context, and

gives the MWAs a voice within research. This study potentially supports management in setting up organisation and individual-specific coping strategies and well-being programmes to improve the MWAs' current health status.

7.6 Implications for future research

The analysis and discussion of findings from this exploratory study on stress and coping among MWAs, have revealed areas for future research. The need for more qualitative (phenomenological) research is apparent and should be conducted with MWAs outside the South Western Nigerian region to establish whether they experience similar stressors and to identify the coping mechanisms adopted. This will help determine whether this is a trend within hospitals across Nigeria and build on the foundations laid by the current study to create more evidence for policy reform. Additionally, this will address the lack of studies investigating occupational stress among MWAs and reduce the dearth of published qualitative literature, both locally and internationally.

Future studies should explore senior staffs' perceptions of occupational stress and their understanding of the role of MWAs. This could result in an increased level of recalibration of expectations thus influencing the understanding and awareness of the role, and more appropriate delegation of duties. Such studies could also establish any inconsistencies or similarities in the role across different regions.

It will be worthwhile to explore these concepts from an international perspective, in terms of having an understanding of stress among MWAs or their counterparts in different countries. Although this study made an important contribution in examining stress among an under-represented group of workforce, it is limited and the themes that emerged should be explored further with future international studies. This will be beneficial in the globalised context, where national and international dimensions are more interwoven within policies. This will enable a fuller understanding of occupational stress among the MWAs and nations can look beyond their borders for solutions to common problems or establish common standards in policies. For instance,

findings from these studies can contribute to achieving the United Nation's SDG 3, by ensuring and improving the health and well-being of all, including MWAs and retaining an adequate pool of health workforce.

Finally, this study laid the foundation for the future research needed on the most effective means by which staff in support roles with limited power and authority could be supported to reduce the impact occupational stress has on their work and personal life.

7.7 Dissemination strategy for the study findings

Ethically there is a need to disseminate research findings (Robson and McCartan 2016). In terms of disseminating the findings of this study, this process has began already with presentations at different research gatherings. This included presentations to staff and other PhD students at research workshops within the Faculty of Health Studies. Additionally, information on this study was presented in the form of a poster at the 2015 Making Diversity Intervention Count 5th International Conference in University of Bradford.

Relevant journals have also been identified and a detailed overview of the research and findings will be submitted to them for publication. These include *Work, Employment and Society, British Journal of Midwifery, Work and Stress and the West African Journal of Nursing*. Publications in these journals will contribute to the body of knowledge on occupational stress and coping from a Nigerian perspective in the literature. Furthermore, this will include the voice of the MWAs within the available literature.

Additionally, abstracts have been accepted for conference presentation and the researcher is due to present the research findings at the Work, Stress and Health (2017) 'Contemporary Challenges and Opportunities' and the International Labour Process Conference in Sheffield.

7.8 Limitations of the study

All steps possible were taken to ensure a robust approach to the research design and the execution of data collection throughout the study. However, there are a number of limitations that will now be discussed.

The MWAs in this study were from a particular region of Nigeria and this geographical limitation meant that MWAs from other regions were not included. This was due to logistical difficulties concerning resources, time available for the study, travelling distance between regions and, importantly, security concerns as the research was conducted during a period of political tension in Nigeria. Despite this, the inclusion criteria used in the sampling frame ensured that the hospitals met the requirements of the study as set out in Chapter four. Extending the research beyond this region has been identified for future research to confirm if similar findings would be found.

Although it was not the aim of the study, it could have been worth interviewing the management to get their perspective and also exploring the views of non-MWAs within other departments to determine whether there were similarities or differences across units. This has been identified for future research and would give a holistic picture of stressors in the hospital. Awareness amongst other staff of the MWAs' situation would also have been interesting and would have indicated how receptive they may have been to changing their attitudes to MWA.

The sample might be considered small and may be seen as a limitation of the study. However, in a qualitative study the focus is on the quality of the data obtained, what will have credibility and what is attainable within the available resources, and not on sample size (Patton 2002). Therefore, purposive sampling was adopted to select participants who could provide the rich data the researcher sought.

Despite these few limitations, this study was conducted responsibly and professionally, adhering to all guiding ethical principles, to achieve its aim and objectives.

7.9 Strengths of the study

This study had a number of strengths, which are detailed below.

This study has extended the previous knowledge of the causes of occupational stress among the healthcare staff and included MWAs within the body of research. One of the important strengths of this study was that research has been conducted within maternity settings in Nigeria for the first time.

Additionally, no research studies in Nigeria have used qualitative phenomenology to explore stress. The methodological strength of this study was the qualitative approach adopted. This enabled the MWAs to express their perceptions of occupational stress and highlight the contributory factors and how this impacted on their health and well-being. The MWAs were able to make suggestions to improve their working experiences. Previously, the MWAs were never included in research or given the opportunity to identify issues that affected them at work, whereas this qualitative approach provided a detailed and comprehensive understanding of how the MWAs perceived and coped with stress at work.

In summary, this study is novel and has included an important but under-represented group of healthcare workers within the body of research.

7.10 Reflecting on the PhD journey. a final note

Really? A PhD? That was a response I commonly received from people when I mentioned that I wanted to do a PhD. I was unsure if this was a positive response or a scary indication of what lay ahead. After undertaking my master's degree and writing my dissertation, I was clear about wanting to do a PhD. I had a number of research ideas and areas I wanted to explore, which I carefully defined to ensure a proper focus. This was interesting because it got me digging deeper into the literature and uncovering new knowledge. I feel

privileged to have embarked on this PhD journey and have developed new skills through the supportive community at the University. This journey was not without the usual valleys and peaks but it was worth every ounce of energy, time and sacrifice.

Doing this PhD has given me the opportunity to develop my problem-solving, management, research, writing and oral communication skills, which has contributed immensely to my self-discovery and my personal and career growth, impacting on the next important steps of my life.

As with any other PhD, this study was conducted in phases and each contributed significantly to the journey. I was privileged to explore the experience of a group of hard-working women facing challenging practices in hospital maternity settings in Nigeria. This provided me the opportunity to give a voice to these unrecognised, almost invisible women, who were the MWAs who played a key role within the maternity service. However, their inclusion in this pioneering research is believed to be the beginning of their visibility, not only as an essential part of the workforce, but also as a group that cannot be ignored within the literature. As I listened to the MWAs talk about their work experiences and the impact it had on their health and well-being, it was not difficult to visualise what went on within the hospital environment. Despite this, it was amazing to see how the MWAs continued to work in conditions of such hardship, exhibiting a strong work ethic and resilience.

Being Nigerian, helped me to gain access to the MWAs and made it easier to capture such vital work experience within the maternity setting. This, I believe contributed to the reception I received and gave the MWAs the confidence to provide in-depth accounts of their experiences. Additionally, I regard it as an honour to have been granted permission by the management of the hospitals to access their workforce for this important, piece of research. Hence, the hospitals and MWAs are pioneer participants in this field of research in Nigeria. I believe that if the recommendations are implemented these hospitals will become pace-setters in employment practices and workforce health and a reference point for stress management protocols.

As would be expected in a phenomenological study, I became highly involved in the data analysis, uncovering themes relating to the area of research. This contributed to my abilities in using qualitative methodological analysis.

Throughout the span of this PhD, I have understood stress to be a complex, subjective and multidimensional issue. I also came to realise that the MWAs need to be treated with more respect, irrespective of their background education or status particularly, as the WHO classifies support workers (MWAs) as the invisible backbone the health system cannot function without (WHO 2006).

Therefore, completing this PhD thesis has not only generated new understanding on occupational stress, but it has also allowed me to complete a personal research journey; a journey that marks the beginning of a future research career.

7.11 Tribute to the Maternity Ward Attendants

This thesis has shown that the MWAs are strong women, but they have little or no voice and are almost an invisible workforce within the maternity setting, where they play an important role. Occupational stress is an integral part of the MWAs' experience, a normal occurrence with little hope of any change or improvement in the foreseeable future. Unfortunately, the MWAs do not always cope with stress; even though they highlighted the coping mechanisms they believed helped, these only provided brief relief and arguably had a detrimental effect on their health in the long term. The MWAs have a limited work-life balance, little control over their jobs, low pay and social status, and are held in low regard and apparently not always appreciated by management and senior staff. However, despite these challenges the MWAs demonstrate great resilience, almost by just getting by, the work gets done and they remain committed to maternity care, albeit potentially at a great personal cost to themselves and their families.

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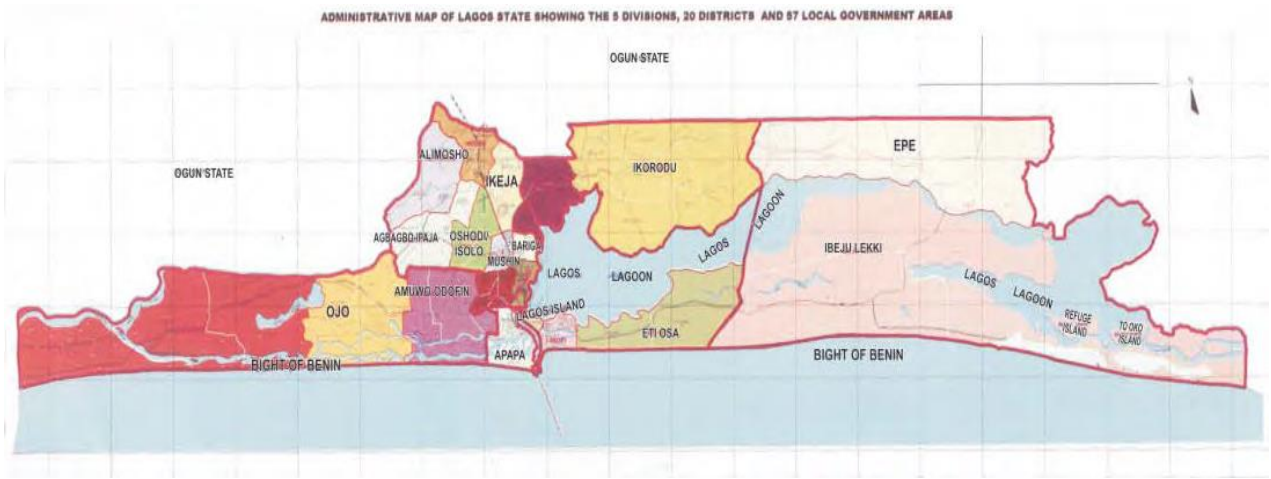
9.0 APPENDICES

Appendix 1: Region of study: Demography of Lagos State (LS)

Lagos state is located in the South West Geo-political Zone of Nigeria and has 20 local government areas (LGAs), each sub-divided into an additional 37 local council developments areas (LCDAs) (LSG, 2016). Until December 1991, Lagos state was the capital city of Nigeria and remains the economic nerve of the country. Lagos state has the largest concentration of industries and major ports in the country. The state houses the major tourist sites, including Bar Beach, Badagry Beach, Tarkwa Bay and Whispering Palms. This is among the reasons it is referred to as the centre of Excellence. However, in terms of health service, excellence cannot be said about the state as it is also still lacking in providing adequate health service to the public, despite having more hospitals than some other states.

Although Lagos state is one of the smallest states in Nigeria, with an area mass of 356, 861 hectares, of which 75,755 are wetlands, it has the highest population of 17.5 as of 2006 and 21 million in 2014, which is over 5 percent of the national estimate (Fig 3) (National Population Commission (NPC) 2014; Lagos State Government (LSG) 2016). The majority (85%) of this population is located within the metropolitan area, a location covering 37% of the land area of Lagos state. The state has a growth rate of 3.2% with about 4.3 million children based on immunisation records (LSG, 2016).

Figure 6: A map of Lagos state in the South West region of Nigeria



Source: Adapted from Filani (2012).

Appendix 2: Levels of healthcare delivery

Government tiers	Description of health delivery system.
Primary (local) level	This level forms the entry point of the community into the healthcare system. They consist of the health centres and clinics, dispensaries and health posts, providing basic preventative, curative, promotive and pre-referral care to the general population. The health facilities at the local level are typically staffed by nurses, community health extension workers (CHEWs), junior CHEW and environmental officers. The national health policy regards the primary health centres as an important part of a framework to achieving improved maternal and child health.
Secondary level	The facilities within the secondary care system include the general hospitals and provide general medical and laboratory services, including specialised health services, such as surgery and paediatrics, obstetrics and gynaecology to patients that were referred from the primary healthcare centres. These facilities are usually staffed by medical officers, nurses, midwives, community officers, laboratory and pharmacy specialists. It is also noteworthy that the primary and secondary level of healthcare is also largely provided by an unregulated private health sector that performs major procedures without proper facilities and adequate human resources.
Tertiary level	This level of care forms the highest healthcare system in the country, with specialist and teaching hospitals. These facilities treat patients referred from both the primary and secondary level with special expertise and fully-fledged technological capacity that enables them to serve as a resource location for knowledge generation. Although the standards within these hospitals are yet to meet up with what is expected as seen in other developed countries, slow advancements are being made in developing facilities required to care for the huge population within the country. However, the supply of much required modern equipment is limited to the federal hospitals, with only 8 out the 14 federal teaching hospitals adequately equipped and 6 are yet to be equipped.

Source: WHO (2002).

Appendix 3: The MDGs and their targets

MDGs	Goal	Targets
MDG 1	Eradicate extreme poverty and hunger.	1A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day. 1B: Achieve full and productive employment and decent work for all, including women and young people. 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
MDG 2	Achieve universal primary education.	2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of basic schooling.
MDG 3	Promote gender equality and empower Women.	3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.
MDG 4	Reduce child mortality.	4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.
MDG 5	Improve maternal health	5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. 5B: Achieve, by 2015, universal access to reproductive health.
MDG 6	Combat HIV/AIDS, malaria and other diseases.	6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS. 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.
MDG 7	Ensure environmental sustainability.	7A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

		7B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss. 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.
MDG 8	Develop a global partnership for development.	In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries.

Source: Summarised from UN (2000)

Appendix 4: Sustainable Development Goals

Goal 1.	End poverty in all its forms everywhere
Goal 2.	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5.	Achieve gender equality and empower all women and girls
Goal 6.	Ensure availability and sustainable management of water and sanitation for all
Goal 7.	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8.	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9.	Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation
Goal 10.	Reduce inequality within and among countries
Goal 11.	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12.	Ensure sustainable consumption and production patterns
Goal 13.	Take urgent action to combat climate change and its impacts*

Goal 14.	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15.	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16.	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17.	Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development

Source: UN (2015)

Appendix 5: Qualitative methodological approaches

Methodological approach	Description
Grounded theory	Is a methodological approach which aims to generate theories that explain social processes or actions rather than a particular theoretical content (Straus and Corbin, 1998; Ritchie et al. 2014)
Ethnography	Involves understanding the social world or culture, shared beliefs and values of a group, organisation or community by immersing oneself in their community. This involves an approach embedded in observing and interacting with the research participants in their daily lives to understand their culture (Creswell, 2003). This approach does not suit this study as the focus is not the culture of MWAs but on exploring areas around their work experiences working with new mothers to identify stressors and coping mechanisms.
Case study	Approach is an in-depth investigation of a single entity or a small number of entities, which could be individuals or a community (Polit and Beck 2006). The main aim of a case study is to study a case to develop a full understanding of the case as possible which are important to history or circumstances of the case studied (Silverman and Marvasti 2008).

Appendix 6: Interview schedule for Maternity Ward Attendants.

Interview schedule

The interview process will start with a brief introduction to the study by the researcher. This will include a summary of the ethical perspective to ensure participants fully understand their rights within the study, including the digital recording and transcription and, to ensure they are comfortable with the interview proceeding. Participants will be reminded about matters concerning confidentiality, including refraining from using the names of patients/mothers, relatives or staff. Any inadvertent mention of names will be deleted from the transcript.

Interview questions: The areas to be explored in the interview schedule will be structured around the aim and objectives of the study. Questions in italics will be used as prompts during the interview which are not intended to lead the participants but will be used for clarification and focus.

It will be important to put participants at their ease prior to commencing the interview.

Opening question

Q1. Can you talk me through your typical working day?

- Can you tell me about your role within the hospital/centre?
- *Can you describe a good shift?*
- *Can you describe a bad shift?*

Perception of occupational stress

Q2. What does stress at work mean to you?

Q3. How do you recognise that you are stressed?

- *Symptoms of stress: poor concentration, anxiety, tiredness, irritable etc.*

Q4. What are your experience(s) of work related stress?

- Can you tell me if you have taken time off work due to work related stress?
- How often does this happen?

Factors that causes/contributes to occupational stress

Q5. What do you find most stressful at work?

Q5a. What do you think are the possible causes?

Impact of occupational stress on Maternity Ward Attendant's health and well-being

Q6. If stress affects you, in what way does it do so?

- *Would you say it affects you emotionally? How?*
- *Would you say stress causes you any physical effects? How?*

Coping mechanisms adopted by Maternity Ward Attendants

Q7. How do you cope with work related stress?

- *Keep it to yourself?*
- *Would you share this with other* Maternity Ward Attendants*?*
- *Would you share this with other qualified staff?*
- *Do you feel you discuss stress outside work?*
- *Do you share this with your family?*
- *Do you share this with your friends?*
- *Do you share this with the mothers/patients/clients?*

Q8. Do you have any particular approaches to coping with your workload?

- Do you have competing (different) demands placed on you at work*?*
- *Can you tell me what they are?*
- *Can you talk to me about how effective your coping strategies have been?*

Q9. Can you think of a situation where you did not cope with work related stress?

Q10. Have you ever noticed any symptoms of stress in your colleague?

- *What where they?*

Q11. Has anyone ever approached you for support?

- *Can you tell me about such a situation?*

Q12. Have you ever supported a colleague that was stressed at work?

- *Can you tell me about such a situation?*

Q13. Have you felt able to provide this support?

Support available within the hospital/centre

Q14. What sort of support is available to you?

E.g support from your employer, colleagues, yourself, home, friends or new mothers.

- *Is this support effective? How?*
- *If not why not?*
- *How do you think support could be more effective?*

Q15. Is there anything you would like to suggest to improve your experience as a Maternity Ward Attendant?

To conclude the interview the following questions are asked:

Are there any areas you have thought of that I did not ask?

Is there anything else you would like to discuss?

Thank you for your taking time to participate.

Appendix 7: Biographic details of participants being interviewed

The interview will commence with general questions, which are designed to provide some biographic information about the research population and to put you at ease.

Please place a tick in the box that provides the most appropriate answer:

Gender: Male ☐ Female ☐

Age: 18-20 ☐ 21- 25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56 and above ☐

Do you work: ☐ Full time ☐ Part time ☐ Flexible?

Length of time working as a MWA: 0-2 years ☐ 3-4 years ☐ 5 years and above ☐

How long have you worked at this hospital(s)/centres: 0-2 years ☐ 3-4 years ☐ 5 years and above ☐

Are you employed as a: Permanent staff ☐ temporary staff ☐

If you a permanent staff, have you worked in any other hospital/centre before? Yes ☐ No ☐

If Yes, for how long? ☐ 0-2 years ☐ 3-4 years ☐ 5 years and above

How many years of experience do you have working with pregnant women and/or new mothers? 0-2 years ☐ 3-4 years ☐ 5 years and above ☐

How long does your typical shift last? Less than 4 hours ☐ 5-8 hours ☐ 7-8 hours ☐ 12 hours ☐ other ☐

What shifts do you work most? Nights ☐ Day ☐ or Equal combination ☐ of both

How often do you work? Once a week ☐ twice a week ☐ three times a week ☐

Four times a week☐ other☐

What is your highest level of education? W☐CGCE ☐ NECO☐ OND ☐

HND ☐

Others_____

Appendix 8: Letter to medical directors

UNIVERSITY of BRADFORD
Faculty of Health Studies
Richmond Road
Bradford
West Yorkshire
BD7 1DP
Tel: 01274236300

LETTER TO THE MEDICAL DIRECTORS

Dear Sir/Madam,

I am a PhD student in the Faculty of Health Studies at the University of Bradford, in the UK. My research interest is in improving the health and well-being of Maternity Ward Attendants in a maternity care/hospital setting.

As part of a PhD research study, I am undertaking exploratory research focusing on the Maternity Ward Attendants' perception of work related stress and means of coping when working within a maternity care setting.

I am writing to seek your permission to include your hospital in this research study and to request permission to approach your Maternity Ward Attendants to invite them to participate in my research study. Participation will be on a voluntary basis. This will enable me to gather the required information for this research study. All information related to this research study will be treated with strict confidentiality.

The outcome of my research study is to identify stressors and propose means of alleviating them, thus improving the effectiveness of the very important contribution made by Maternity Ward Attendants. It is hoped that in turn, this will improve the services offered to pregnant women and new mothers.

When completed, the research study has the potential to be beneficial not just to your hospital by increasing the capability of your Maternity Ward Attendants to work effectively, but also to maternity services providers further afield.

If your permission is granted I will be pleased to meet with you to speak about the practicalities of the research study and answer any questions that you may have.
Please find enclosed a response form and a copy of the letter that will be sent to the Maternity Ward Attendants if you agree for me to approach them to consent to participate. A pre-addressed envelope will be provided with all letters to Maternity Ward Attendants.

I will be grateful if you would please give my request your kind consideration and I look forward to hearing from you.

Oluwatoyosi Kuforiji
PhD Student
Faculty of Health Studies
University of Bradford
Bradford.
UK
Tel: 01274 236403

Appendix 9: Medical director's response form

UNIVERSITY of BRADFORD
Faculty of Health Studies
Richmond road
Bradford
West Yorkshire
BD7 1DP
Tel: 01274236300

MEDICAL DIRECTOR'S RESPONSE FORM

Research title: Qualitative study exploring Maternity Ward Attendants' perceptions of occupational (work related) stress, and coping methods adopted within maternity care settings/hospitals in Nigeria.

Researcher's Name: Oluwatoyosi Kuforiji.

I _____ have read the information contained in the letter about the above research study, which describes what will be required if Maternity Ward Attendants volunteer to participate in the research study and

◯ Yes- I would like to include this hospital/centre in the research study

◯ No- I do NOT wish to include this hospital/centre in the research study

Name of the hospital _____

Contact details _____

Signature_____Date_____

Appendix 10: Letter of approval 1

LAGOS STATE GOVERNMENT

4th May, 2015

[redacted]

RESEARCH ETHICS COMMITTEE

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

RE: Qualitative Study exploring maternity Ward attendant's perceptions of occupational (work related) stress and coping methods adopted within Maternity care setting/Hospitals in Nigeria

Name of Principal Investigator: **Oluwatoyosi Kuforiji**

Address of Principal Investigator:

University of Bradford, Faculty of Health Studies, Bradford, West Yorkshire.

Date of recipient of valid application: 27th April, 2015

Date of meeting when final determination of research was made: 30th April, 2015.

This is to inform you that the research described in the submitted protocol, the consent forms, Advertisement and other participant information materials have been reviewed and given full approval by the Health Research ethics Committee.

This approval dates from 30th April, 2015 to 2nd May, 2016. Is there is delay in starting the research, please inform the Health Research Ethics Committee so that the dates of approval can just be adjusted accordingly.

Note that no participant accrual or activity related to this research may be conducted outside these dates. **All informed consent forms used in this study must carry the HREC assigned number and duration of HREC of the study.** In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code including ensuring all adverse events are reported to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the code. The HREC reserves the right to conduct compliance cisit your research site without previous notification.

[redacted]

Appendix 11: Letter of approval 2

LAGOS STATE GOVERNMENT

[redacted]

18th May, 2015

TO WHOM IT MAY CONCERN

RE: KUFORIJI OLUWATOYOSI
REQUEST T O CARRY OUT RESEARCH PROJECT

This is to introduce the above named PhD Student in the faculty of Health Studies at the University of Bradford, UK who seek for permission to carry out a research project on Qualitative study exploring Maternity ward Attendants' perceptions of occupational (work related) stress and coping methods adopted within maternity care settings (hospital) in Nigerian.

Please accord her all necessary assistant towards achieving this goal.

Thank you

[redacted]

[redacted]

Appendix 12: Letter to the maternity ward attendants

UNIVERSITY of BRADFORD

Faculty of Health Studies
Richmond road
Bradford
West Yorkshire
BD7 1DP
Tel: 01274236300

LETTER TO THE MATERNITY WARD ATTENDANTS

Dear Maternity Ward Attendants,

I am a PhD student in the Faculty of Health Studies at the University of Bradford, UK. My research interest is in improving the health and well-being of Maternity Ward Attendants working in maternity care setting/hospital.

As part of my PhD study, I am undertaking an exploratory research study focusing on the Maternity Ward Attendants' perception of work related stress and means of coping when working within a maternity care setting. Your Medical Director/Apex nurse has given me permission to write to you.

I am writing to ask if you would consider volunteering to participate in this research study. If you agree to participate, you will be invited to meet with me to discuss the important topic of work related stress. The discussion will take place at a venue and time that suits you and will not take longer than an hour. Please see the attached information pack for more details about the research, the researcher's contact details and what your participation entails. Please sign the attached form if you agree to participate. With the permission of the Medical Director/ Apex nurse, I will come at a mutually agreed time to talk about the research study.

The outcome of my research study is to identify stressors and propose means of alleviating them, thus improving the effectiveness of the very important contribution made by your role as a Maternity Ward Attendants. It is hoped that in turn, this will also improve the services offered to pregnant women and new mothers within hospitals/centres.

I will be grateful if you would please give my request your kind consideration and I look forward to hearing from you.

Oluwatoyosi Kuforiji
PhD Student
Faculty of Health Studies
University of Bradford
Bradford.
UK.

Appendix 13: Information sheet

Participant information sheet for the Maternity Ward Attendants

Research title: Qualitative study exploring Maternity Ward Attendants' perceptions of occupational (work related) stress, and the coping methods they adopted within maternity care settings/hospitals in Nigeria.

Thank you for reading through this information sheet which explains my research study and answers some of the questions you may have.

Researcher's Name: Oluwatoyosi Kuforiji.

About the researcher:

I am a PhD student at the University of Bradford, United Kingdom (UK) in the Faculty of Health Studies. My research interest is concerned with enhancing the health and well-being of Maternity Ward Attendant working in a maternity care setting.

You are invited to take part in this research which aims to make recommendations based on the information gathered as part of the research study. Therefore, before deciding on whether or not you wish to participate please read the following information to understand why the research is being undertaken and what your participation would entail.

What is this research about?

Over the years there have been a number of research studies which have explored the working experience of health staff, such as nurses and midwives working in a maternity care setting. However, there have been very little research findings published about the Maternity Ward Attendants (MWA) roles when working with pregnant or new mothers in a maternity care/hospital settings in either the UK or Nigeria. I am, therefore, undertaking this research study to gain a better understanding of the working experience of the Maternity

Ward Attendants within the maternity care setting with the aim of increasing the body of knowledge concerning Maternity Ward Attendants, the effect their work has on their health and well-being and to make recommendations where appropriate.

Why have I been asked to take part?

You are being approached to participate in this research study because you are a Maternity Ward Attendant working in a maternity care setting/ hospital. You have the relevant work experience that the researcher wishes to explore in order to gain an understanding of what stress means to you and how you are able to cope with it.

Do I have to participate in this research?

It is entirely your decision whether or not to participate in this research study. Irrespective of your choice, your decision will be confidential between you and the researcher. Furthermore, this will not affect your employment within the maternity centre/hospital in any way, nor do you have to give a reason for not wishing to take part to anyone.

What happens if I decide to take part?

You will be asked to consent to be interviewed. This will entail signing a consent form. All interviews will be undertaken by me as the researcher for this study. The consent form is a mini questionnaire with tick boxes providing more information about your approval to be interviewed. This should take you no more than 5 minutes to fill out and sign. Your consent is entirely voluntary and if you participate you can choose to withdraw at any time during the research study. The interview should last about an hour and will be conducted at your place of work or at a place convenient to you and that is suitable for an interview. The interview will involve me talking to you about your work experience and will be digitally recorded (if you agree) with a voice recorder.

What happens to the recording?

Unique codes will be allocated to *transcripts which enables the researcher to identify the interviews but will NOT include your name or where you work. Anonymised data will be shared with the researcher's *supervisor or discussed

when required. In addition, if you wish to have a copy of the transcript, this can be posted to your workplace or home address (if preferred), addressed to you in an envelope marked confidential. The audio recordings will be securely stored in accordance to the UK Data Protection Act (1998). The recordings and transcripts will be backed up in a password protected folder on the researcher's computer for further analysis. In addition, the digital recording will be kept securely with only the researcher having access to it. Importantly, all the data will be destroyed when the research study is complete.

Are there any negative effects associated to partaking in this research?

The researcher does not envisage any negative effects or risk as a result of partaking in this research study. However, during the interview if you feel uncomfortable with any of the questions about your working experience, there is no obligation to answer them.

Will my identity be protected?

All the information collected about your participation in the research study will be kept strictly confidential. Your identity will not be revealed to any other persons, nor will it appear in the research reports or any associated publications. All personal details provided within this research study will be treated with uttermost confidentiality. The front sheet containing your name(s) and other personal details will be removed and stored separately once unique participant numbers have been assigned to each transcript as previously described. All details will be destroyed when the research study is complete.

What happens to the research findings?

The research study findings will be analysed and summarised into a report format, which will be part of my PhD thesis*. The result of the research will also be shared through writing articles or through public presentation at conferences; however, although anonymised quotes may be included in publications, no information that might identify you personally will be included at any point when sharing the results of the research study. Any Maternity Ward Attendant who wishes to have a summary of the overall findings will be provided with this.

What do I do if I have further questions before deciding to participate?

You are free to contact me, using the details given at the bottom of this information sheet, and I will endeavour to answer your questions.

What do I do if I am interested in participating?

If you have read the information detailed above and you are interested in participating in the research, please complete and sign the attached consent form. Kindly seal this in the envelope and drop in the collection box provided. I will call to collect the completed consent form in person.

Who approved this research study?

This study was submitted to the University for ethical approval to protect your rights, safety and well-being. The research study was granted ethical approval on the 18th of February, 2015 by the Humanities, Social Sciences and Health Studies Research Ethics Panel at the University of Bradford, UK.

Who do I contact if I have any concerns or query?

If you have further concerns about this research study, please do not hesitate to contact me by email at O.A.Kuforji@student.bradford.ac.uk and by telephone on 01274 236403 and I will arrange to discuss any concerns or answer your queries. If you want any additional information about the research study, please contact the researcher's supervisors, Prof. Gwendolen Bradshaw by email at G.Bradshaw@bradford.ac.uk and Dr. Julie Prowse by email at J.Prowse@bradford.ac.uk.

Thank you for taking time to read through this information sheet.

Kind regards.

Oluwatoyosi Kuforiji.

Appendix 14: Consent form

Interview consent form

Study title: Qualitative study exploring Maternity Ward Attendant's perceptions of occupational (work related) stress, and the coping methods they adopted within maternity care settings/hospitals in Nigeria.

Researcher: Oluwatoyosi Kuforiji

Please tick/initial the box to confirm acceptance

Understanding

1. I confirm that I have read and understood the participant information sheet I received from the researcher for this research study. ☐
2. I have understood the purpose of this research study ☐
3. I know what my participation in this research study will entail. ☐
4. I know I can request more information at any time during the research study ☐
5. I understand that participation in the research study is entirely voluntary. ☐
6. I confirm that I have had an opportunity to ask the researcher questions about the research study. ☐

   If you have asked any questions, please answer question 6a

6a. I confirm my question(s) received satisfactory answer(s). ☐

Consent

7. **I** consent to participate in an interview as part of the research study. ☐

   Please answer either question 8 or 9

8. I consent to my interview being digitally recorded. ☐
9. I do not consent to my interview being digitally recorded. ☐
10. I understand my responses will be strictly confidential. ☐
11. I understand all details linked to my identity will be stored separately and subsequently destroyed. ☐
12. I understand that anonymised quotes from my interview may be used within the research report and in any related written publications. ☐

13. I understand that I may withdraw from the research study at any point without giving any reason for withdrawal. ☐
14. I have read the consent form and voluntarily consent to participate in this research study. ☐

Participant Identification number [to be allocated by the researcher] _____

_____ _____

_____

Name of Participant Date Signature

Appendix 15: Ethical models/theories

Theory	Description
Deontology	Research is driven and judged by intent
Consequentialism	Prioritises the goodness of an outcome and actions leading to such outcomes are judged by their consequences.
Virtue ethics of skills	Lays a great emphasis on a researcher's moral values and ethical skills in reflexively accessing ethical dilemmas in research.

Source: (Mauthner 2008)